7.0 Training and Education: What is Needed to Prepare Nursing Assistants to Deliver Good Care[1]

7.1 Introduction

As other chapters in this study have shown clearly, staffing numbers alone have a significant effect on quality of care and quality of life in nursing facilities. Also vitally important to the delivery of good care, however, is ensuring that nursing assistants have the knowledge, preparation, support and supervision necessary to do their jobs with competence and confidence.

This chapter covers what nursing assistants need to know in order to recognize and respond to resident needs, and how they learn to perform tasks of care and work collaboratively with others on a care team. It is based on the following definitions, assumptions, and parameters:

- The purpose of educating nursing assistants is to prepare them to deliver good care to residents and to recognize and respond to resident care needs with confidence and competence.

- A first step to evaluating educational programs is understanding the roles and responsibilities of certified nursing assistants. What are they called upon to do? What kinds of knowledge and thinking skills must they draw upon?

- "Training" is too narrow a word to encompass the wide range of education and reinforcement that a student needs to assume the responsibilities of a nursing assistant. Training prepares a person to perform a task or a job. Education implies knowledge or cognitive ability to recognize and understand abstract concepts.

- Too often, the federally mandated pre-employment certification training is a nursing assistant's first, last and most substantive exposure to formal education. A comprehensive

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approach to education provides many ongoing opportunities for different types of learning such as:

- Transferring learning from the classroom to the clinical setting;
- Gaining and incorporating new knowledge and skills;
- Receiving support, supervision and feedback to reinforce the learning;
- Teaching and supporting peers; and
- Competency checks and remediation.

With these parameters in mind, the research team sought answers to the following questions:

What effects do educational programs have on care quality and continuity?

- Does a nursing assistant's education affect the quality of care that he or she delivers?
- Does education affect retention and turnover rates?
- Does access to education affect recruitment of potential nursing assistants?

What is currently taught?

- What topics are included in the federally mandated pre-employment training programs?
- How are these curricula taught? What qualifications and training do the teachers have?
- What is included in the mandated 12-hour annual in-service programs?
- How have states added to the federal educational requirements?
- What do CNAs say about the usefulness of existing programs?
- Where do the certification training programs take place? Under whose auspices? Are provisions made for consistent outcomes?
- Who pays for certification training? Is the cost a barrier to entry for nursing assistants, or an undue burden for nursing facilities?

What important areas are not likely to be covered adequately in the course of a nursing assistant's education?

- Orientation and supervision;
- Cross-cultural communication and competence;
- Problem solving;
- Critical thinking;
- Communication with residents and their families, peers and supervisors;
- Leadership;
- Stress management;
- Managing difficult workloads; and
- Serving clients with certain disabilities or diseases.

What role do career advancement programs play?

How common are career ladder programs for nursing assistants, and how do they work?

What could be done to improve the current system?

The chapter concludes with a list of recommendations.

7.1.1 Executive Summary

This chapter looks at nursing assistant education and its effect on resident quality of life and quality of care in nursing facilities.

Education is broadly defined to include not just the certification training and testing required of all new nursing facility nursing assistants or the 12 hours of mandated in-services per year but also an array of other programs and systems that nursing assistants need in order to feel confident and competent in doing their jobs. These include orientation, supervision, organizational support, ongoing education, opportunities for career advancement, support services to prepare marginal workers and those who need to improve their English skills for the workforce, and special training to help workers cope with the multiple physical, emotional and organizational demands of the job.

Although nursing assistant work is often perceived as unskilled, nursing assistants perform a complex and key function in nursing facilities. As Section 7.3 explains, nursing assistants are the most important person in most residents' lives. As such, they must be inclined by nature, prepared by training, and empowered by their facilities to offer not just physical but emotional support. Because nursing assistants are so important to residents' quality of life, frequent turnover in that position can have a significant negative impact. While many factors affect the turnover rate in an average facility, research indicates that adequate training, orientation and supervision play a key role.

As Section 7.6 details, there were no federal requirements for nursing assistant training until the Omnibus Budget Reconciliation Act (OBRA) of 1987 mandated that they have a minimum of 75 hours of training, pass a certification exam and skills test, and follow up with 12 hours a year of in-service education. Many states require more hours, mandate specific topics that must be taught, or both. These rules were passed in reaction to reports from the Institute of Medicine and elsewhere in the 1980s indicating that the quality of nursing home care was seriously deficient, and that nursing assistants were one of the key players in delivering quality care.

Approximately 14 years after the passage of OBRA '87, however, many long term care stakeholders are concluding that its mandates for initial training of nursing assistant training did not go far enough. There is also a general consensus that in-service classes tend to be repetitive and boring, and that they are not tailored to meet the needs of individual nursing assistants, or to reflect the special needs of a facility's population.

Perhaps because formal training does not go far enough, evidence points to the fact that nursing assistants learn many crucial skills on the job. In the process, they often learn ways of cutting corners that allow them to shoulder often burdensome workloads but do not account for individual residents' needs or preferences.

Section 7.8 explains how the certification training mandated by OBRA ranges widely in style, quality and content depending on the individual instructor, the requirements of the state in which they are taught, and perhaps the location of the classes. Some classes are taught in nursing facilities; some in community colleges, vocation-technical colleges, or high schools; and some in private schools. The basic curriculum includes personal care skills and certain basic medical procedures, with some time spent on common conditions associated with aging. Some adult education methods are often used to convey the material, but lectures and written texts generally predominate. The curricula often look impressive on paper, but covering all that ground effectively in 75 hours or slightly more is a challenge. In addition, teachers are required to have only minimal preparation other than a background in nursing, and some lack training in adult education.

The tests for certification are developed and administered separately from the curricula for certification classes. As a result, some say, the subject matter does not always jibe, and students may be tested on material they were not taught.

As described in Section 7.9, more problems surface when idealistic new students attempt to transfer their learning to the worksite. Many learn that there is no time to do things the way they were taught, leaving them to weigh the necessity for using shortcuts against their reluctance to compromise resident care or quality of life. Often, these decisions must be made without the help of effective orientation, supervision or organizational support.

The certification and ongoing education mandated by the federal government is supposed to be paid for by the government, but all costs are not always covered, leaving nursing facilities or nursing assistants themselves to pick up some of the expenses. This can create a financial burden for facilities and serve as a barrier for nursing assistant candidates, many of whom are living on the brink of poverty.

Section 7.12 outlines the elements that are commonly missing in preparing nursing assistants for the job, from a failure to recruit the right candidates to a lack of English as a Second Language (ESL) classes and other support services to enable others to attend classes to an absence of key content areas in most training that leaves new nursing assistants poorly prepared for the realities of the job. For instance, few certification classes teach problem solving and critical thinking, how to communicate with residents and their families, how to get along with supervisors and peers, and how to manage a difficult workload, although these are all skills most nursing assistant must draw on daily.

Section 7.13 looks at career ladders for nursing assistants, outlining how they are defined and what elements they tend to include and noting that they are more the exception than the rule,

although evidence indicates that they help retain nursing assistants by providing motivation and recognition for learning skills or acquiring knowledge beyond the basics. Sections 7.14 through 7.16 offer examples of current training programs and related initiatives sponsored by states, providers, trade unions and others. While the researchers were unable to do an exhaustive search for the best practices in the field, these programs provide a variety of examples of promising practices, which other facilities may be able to adapt.

In Section 7.17, recommendations for improving nursing assistant education and ongoing training are formulated by the Paraprofessional Healthcare Institute. Divided into recommendations for the Centers for Medicare and Medicaid Services (CMS), for states, and for nursing facilities, these describe an educational approach, structural framework and set of relationships that need to be in place in order to develop and sustain training and educational opportunities that will prepare nursing assistants to deliver good care to nursing home residents.

In general, the recommendations focus on expanding the training requirements for CNAs. "Raising the bar" for entrance into the nursing assistance field might seem counter-intuitive at a time of such widespread vacancies throughout the industry, but these recommendations are based on an assessment that *retention* of nursing assistants once in the field is the primary solution to addressing vacancies—not simply attracting more, less prepared, new applicants.

7.2 Methods

Relatively few articles in peer-reviewed medical or professional journals have focused on nursing assistant education. Of those, most describe a program with a narrow focus, such as incontinence or dementia care, which was implemented in one or two facilities and may not be easy to replicate.

Literature review

A search of PubMed brought up a number of relevant articles. Other books, articles and unpublished papers and studies were recommended by key contacts (see below). Citations in these articles led to other material of interest, all of which is listed in the bibliography following this chapter.

Key contacts

A number of key contacts reviewed our initial outline or shared their insights into some or all of the material covered. Most also recommended promising educational programs and relevant literature. These contacts included nursing assistants, researchers, nursing facility administrators, trade association staff, nursing assistant educators, state nursing assistant education supervisors, and consumer advocates.

Site visits

Visits to federally mandated certification training programs in the Baltimore, Philadelphia and Boston regions helped illustrate variations in class content and teaching methods.

Promising practices
Recommended by our key informants, the promising programs described in Sections 7.15 and 7.16 represent a range of intriguing possibilities sponsored by nursing facilities, community colleges, state and county governments, unions, educational institutions, and other non-profit entities.

State requirements
The research team collected data on state mandates from earlier studies and examples of state-approved programs from key informants.

It is anticipated that additional information on this topic will be available shortly from the Office of Inspector General of the Department of Health and Human Services, which is conducting a 50-state survey of CNA educational and training requirements, including extensive interviews in New York, Washington, Louisiana, Minnesota, and Florida.

7.3 Nursing Assistant Profile

> "We've continued to look at NAs for years as an amorphous mass of people who do what nobody else wants to do. And how do you get any kind of satisfaction out of having a job like that? How do you feel valued?"[2]

7.3.1 What Nursing Assistants Do on the Job

Nursing assistants constitute the largest group of workers in nursing facilities (approximately 43 percent).[3] They interact more with residents than any other members of the staff, providing approximately 90 percent of the hands-on care [4-5] and serving as the "eyes and ears" of the nurses they report to.

The job is physically demanding as well. Nursing assistants spend hours on their feet, often lifting or transferring incapacitated residents. They are frequently exposed to hazardous chemicals and blood borne pathogens. And residents with dementia often strike out at nursing

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2 Genevieve Gipson as quoted in Pair power: For veteran nursing assistants, partnerships with peers provide support and stability. *Contemporary Long Term Care*, February 1996.

3 U.S. General Accounting Office (GAO, May 17, 2001). Nursing workforce: Recruitment and retention of nurses and nurse aides is a growing concern, Figure 4. Testimony before the Committee on Health, Education, Labor and Pensions, U.S. Senate

4 Waxman HM, Carner EA, Berkenstock G. (1984). Job turnover and job satisfaction among nursing home aides. *Gerontologist* 24: 503-509

5 Bowers B; Becker M. (June 1992) Nurse's aides in nursing homes: the relationship between organization and quality. *Gerontologist* 32(3):360-6

assistants. As a result, nursing facility nursing assistants have one of the highest on-the-job injury rates of any type of U.S. worker,[6] totaling 15.9 percent in the most recent government survey.[7]

Their responsibilities vary depending on state regulations and facility policy, but virtually all nursing assistants watch for significant changes in a resident's condition, including signs of depression, mental confusion, or incumbent pressure ulcers. They help residents eat, dress and undress, bathe, transfer, ambulate, and maintain range of motion. They help with toileting; care for residents' mouths, skin and nails; and reposition residents who can't move. They fill out paperwork documenting much of what they do. And they take temperature, pulse, respiration and blood pressure readings; record intake and output of fluids; make beds and clean rooms; and provide postmortem care. Another responsibility is rarely included in official lists of what nursing assistants do, but it may be their most important one: forming relationships with residents.

The work of a nursing assistant is emotionally demanding. Caring nursing assistants grow close to at least some of "their" residents only to watch them suffer losses and indignities, grow sicker, or die. As one nursing assistant recently wrote to a listserv in welcoming a new member to the profession: "If you think it's easy, think again. It's demanding and overwhelming, especially your first day. EVERYTHING will hurt ... including your heart."[8]

The work is emotionally rewarding as well. The main reason nursing assistants stay in the field is their commitment to the residents they care for.[9] Of all the complex, often volatile relationships to be found in nursing facilities, the relationships between nursing assistants and residents are paramount to most nursing assistants—and most residents.

7.3.2 The Importance of Nursing Assistants to Residents

For a 1985 study, the National Citizens' Coalition for Nursing Home Reform (NCCNHR) asked 455 nursing facility residents to talk about what factors had the most influence on their quality of care and quality of life. The most important single factor, the residents agreed, was well-trained staff who were friendly, cheerful, competent and polite. The study participants discussed all level

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6 Service Employees International Union (1997). Caring till it hurts: How nursing home work is becoming the most dangerous job in America. Washington, D.C.

7 U.S. Department of Labor, Bureau of Labor Statistics, Survey of Occupational Injuries and Illnesses, 1997. http://www.osha.gov/oshstats/bls/scrv7.html.

8 Jessica Helms, message to NursingAssistant@yahoogroups.com.

9 Iowa CareGivers Association (December 2000). Certified nursing assistant recruitment and retention project final report summary. Iowa Department of Human Services, contracts 99-040 and 2000-008.

of staff, but they mentioned nursing assistants most often.[10] Those findings have been borne out by other studies of residents[11-12] and their family members.[13]

Improving the Quality of Care in Nursing Homes, an Institute of Medicine report, noted that "[n]ursing homes are 'total institutions' in which caregivers, particularly nurse's aides, represent a large part of the social world of nursing home residents and control their daily schedules and activities. This is the total environment for many nursing home residents for the duration of their stay, which may be several years."[14]

Because of the intimate nature of their relationship to residents and the degree to which most residents depend on them for even the most basic needs, a thoughtless or incompetent nursing assistant can do much to erode residents' quality of life. Jackie Coombs, a nursing facility resident, listed 28 of those ways for NCCNHR. Coombs' list includes both sins of commission, such as "Watching TV while working on resident or standing in front of TV so resident can't see it," and sins of omission, such as "Not drawing privacy curtains in warm weather. Residents in bed partially nude."[15]

Pillemer and Moore (1989) identified more serious forms of abuse and neglect in a study that concluded the following: "[I]t does not appear that maltreatment only occurs in isolated, well-publicized incidents, but that it may instead be a common part of institutional life." [16] In a survey of 577 randomly selected nursing assistants and nurses who worked in nursing facilities, the researchers asked questions by phone, guaranteed respondents anonymity, and asked them to report other people's behavior as well as their own in an attempt to encourage candor. Even so, they noted, it was likely that abusive incidents were underreported to some extent. Yet 36 percent reported having seen a colleague physically abuse a resident in the preceding year, 10 percent said they themselves had committed such an act. Psychological abuse was even more rampant, with fully 81 percent of the respondents saying they had witnessed psychological abuse and 40 percent saying they had perpetrated it.

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10 Spalding J. (1985) A consumer perspective on quality care: The residents' point of view. National Citizens' Coalition for Nursing Home Reform (Washington, DC).

11 Grau L, Chandler B, Saunders C. (1995) Nursing home residents' perceptions of the quality of their care. *Journal of Psychosocial Nursing Mental Health Services* 33: 34-43.

12 Deutschmann (August 2001). Redefining quality & excellence in the nursing home culture. Journal of Gerontological Nursing.

13 Duncan M, Morgan D. (1994) Sharing the caring: Family caregivers' views of their relationships with nursing home staff. *Gerontologist* 34; 235-244.

14 Institute of Medicine, Committee on Nursing Home Regulation (1986). Improving the quality of care in nursing homes. National Academy Press (Washington, DC).

15 Coombs, Jackie. What nursing assistants do and do not do. National Citizens' Coalition for Nursing Home Reform (Washington, DC).

16 Pillmer, Karl and Moore, David W. (June 1989) Abuse of patients in nursing homes: findings from a survey of staff. *Gerontologist* 29(3):314-20.

The most common types of physical abuse were excessive use of restraints (witnessed by 21 percent and committed by 6 percent); pushing, grabbing, shoving or pinching a resident (witnessed by 17 percent and committed by 3 percent); and slapping or hitting a resident (witnessed by 12 percent and committed by 3 percent). The most common acts of psychological abuse were yelling at a resident in anger (seen by 70 percent and done by 33 percent), insulting or swearing at a resident (seen by 50 percent and done by 10 percent), isolating a resident inappropriately (seen by 23 percent and done by 4 percent), threatening to hit a resident or throw something at him or her (seen by 15 percent and done by 2 percent) and denying food or privileges (seen by 13 percent and done by 4 percent).

Conversely, a simple act of kindness or care means more than it would in a less "total" environment. As researcher Sallie Tisdale pointed out in *Harvest Moon: Portrait of a Nursing Home*: "Ordinary, even familial things happen here, though often unwitnessed. Wounds are healed, muscles strengthened, faces washed, and hands held. Each small movement is tiny in its fruition, huge in its absence." [17]

The National Council of State Boards of Nursing (NCSBN) has also acknowledged the importance of the care nursing assistants provide, both mental and physical. The NCSBN, which administers licensing exams for nursing assistants, says nursing assistants should be proficient in five areas: mental health and social service needs, resident rights, basic nursing skills, basic restorative services, and personal care skills.[18]

But steadily increasing average resident acuity levels[19] and heavy workloads leave most nursing assistants hard pressed to attend to residents' mental health and social service needs. Even basic care needs often go unmet, as nursing assistants take shortcuts on some tasks and leave others undone altogether. [20]

This creates an ethical dilemma for conscientious nursing assistants, who often feel that they cannot provide the care that their residents need and deserve. As one nursing assistant recently wrote to other members of a listserv: "The amount of work you're expected to do in the time allotted is unreasonable. It's unsafe for yourself and it's unsafe for the resident.... [F]amilies put their loved ones in these facilities thinking they will get the love and care they for some reason can't provide. If they actually knew how these people are rushed to bed, rushed to eat, rushed to pee, and the little things they miss like oral hygiene and lipstick. It's a shame the shortcuts

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17 Tisdale, Sallie (1987). Harvest moon: Portrait of a nursing home. New York: Henry Holt and Company.

18 National Council of State Boards of Nursing, Inc. (1989) Nurse aide competency evaluation program (NACEP). The Psychological Corporation (San Antonio).

19 National Nursing Home Survey, National Center for Health Statistics, U.S. Department of Health and Human Services, 1977 and 1997.

20 Foner, Nancy. (1994) The caregiving dilemma: Work in an American nursing home. University of California Press (Berkeley/Los Angeles/London).

people can be forced to take. Then as CNAs we go home with a heavy heart, feeling that our job wasn't performed right, that we let them down."[21]

The Effect of Nursing Assistant Education on Quality of Care and Quality of Life

As Kramer and Smith (2000) noted, "[r]elatively few studies have attempted to assess the effectiveness of nursing assistant training programs in increasing the participants' knowledge and improving the care they give to nursing home residents."[22]

It is particularly difficult to find research evaluating the effects of OBRA's mandated education, perhaps because it was implemented so recently. Bernard Gross (July 1995) asked 352 long-term care professionals to evaluate quality of care in Pennsylvania's nursing facilities, rating 15 key areas ranging from "effective observation, assessment and reporting skills" to "provision of kind, gentle and caring service." Respondents were asked how well all 15 services were delivered during two time periods: shortly before OBRA's nursing assistant certification and testing mandate when into effect and five years later. They rated all 15 areas as improved after the mandate was enacted, all but two of them (work ethics and reduction in resident abuse) by a significant margin.[23]

Other research has linked improved outcomes to training programs that target a specific area, most often dementia care.

McCallion et al. (1999)[24] found that a group of nursing assistants who attended a series of personalized training, practice and feedback sessions on dementia care were better able afterward to manage "verbally aggressive behaviors such as yelling, physically nonaggressive behaviors such as wandering, and aggressive behaviors such as hitting." The demented residents cared for by these nursing assistants exhibited significantly fewer depressive symptoms at both three and six months after the training, even as they became more disoriented due to the progression of the disease.

Wilner and Shenkman (1993) found a connection between support groups for nursing assistants and resident outcomes. Nursing assistants in 16 facilities participated in support groups for eight months, discussing teamwork and how to communicate with supervisors and peers, as well as technical information about resident care. At the end of the study period, nursing directors in several participating facilities reported that the residents assigned to CNAs who attended the groups experienced fewer problems. One supervisor noted that the

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21 Message from nursing assistant Melissa Lothrop to NursingAssistant@yahoogroups.com.

22 Kramer and Smith, 2000.

23 Gross, Bernard M. (July 1995) Quality of care defined: An analysis of the impact of nurse aide training and competency testing programs on quality of care of residents of long-term care facilities in Pennsylvania. Pennsylvania Department of Education, Bureau of Vocational-Technical Education, Harrisburg, PA.

24 McCallion P, Toseland RW, Lacey D, Banks S (October 1999). Educating nursing assistants to communicate more effectively with nursing home residents with dementia. *Gerontologist* 39(5):546-58.

"teamwork and consistency of care [of CNAs who participated in the groups] did increase. There was the same quality of work every day."

Beck et al. (March 1999) [25] summarize the findings of 15 publications reporting on nine separate studies of dementia training programs for nursing assistants. Of the nine, they found, only one reported no improvements in resident behaviors and/or staff knowledge after nursing assistants underwent some form of specialized training in dementia care. Of the other studies, four reported a decrease in combative or otherwise problematic behaviors by residents. Others reported improvements in residents' intellectual status, motor skills, mental condition (exhibiting less depression, agitation and confusion), and ability to function independently.

Two of the studies incorporated formal monitoring and feedback by supervisors after completion of training, and reported that this combination produced better results than training alone. Other studies have also shown that training cannot significantly improve care quality unless it is paired with effective supervision and organizational support systems (see Section 7.9).

7.4 Who Nursing Assistants Are

Just under 700,000 nursing assistants work in nursing facilities in the United States.[26] About nine in every 10 are women. Nationally, one in nine (11.1 percent) are foreign-born and just over half (56.6 percent) are non-Hispanic whites. African-Americans account for a larger percentage of nursing assistants than of the population in general, but they remain a minority at 31.8 percent. The percentage of black, Hispanic and/or foreign-born nursing assistants is much higher in cities than in rural areas.

Widespread stereotypes about women in general, and nonwhite and foreign-born women in particular, probably account for some of the tendency to dismiss nursing assistants as unskilled workers. As Wilner and Wyatt (1998) put it: "Home care aides especially, but CNAs as well, face a constant struggle against those who perceive or treat them as 'girls' or 'maids.' 'This struggle reflects deep-seated prejudices about poor and working class women, especially African-American and Latin women. Since most workers choose this field as a health-related position, it is particularly frustrating for them to be perceived as glorified domestic service workers.' (Surpin & Grumm, 1990)"[27]

Just over half of all nursing assistants (51.5 percent) are between the ages of 25 and 44. More than a quarter (27.4 percent) attended at least some college.

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[25] Beck C, Ortigara A, Mercer S, Shue V (March 1999). Enabling and empowering certified nursing assistants for quality dementia care. *International Journal of Geriatric Psychiatry* 14(3):197-211; discussion 211-2.

[26] 1999 employment and wages for selected health care occupations and industries. Bureau of Labor Statistics, Occupational Employment Statistics, Washington, DC.

[27] Wilner, Mary Ann, and Wyatt, Ann. (1998) Paraprofessionals on the front lines: Improving their jobs—improving the quality of long-term care, September 10-11, 1998. A conference background paper prepared for the AARP long-term care initiative. AARP (Washington, DC).

Most nursing assistants are their family's primary wage earners. Only 39.4 percent are married, yet over half (56.3 percent) have children under the age of 18. About one in three (32.4 percent) are unmarried with children. Yet wages are low.

The median hourly wage for nursing assistants, orderlies and attendants was $8.29 in 1999. [28] As a result, many workers live in poverty. Eighteen percent of all nursing facility nursing assistants have family incomes below the federal poverty level, 13.5 percent use food stamps, and 56 percent live at less than twice the poverty level.[29] The median annual salary for a nursing facility nursing assistant is $13,287, just 120 percent of the poverty level for a family of two. [30]

Health insurance is out of reach for many. According to Wilner and Wyatt (1998), only 36 percent of all frontline workers have the option of getting health insurance through their jobs, and 28.5 percent have no health insurance at all.[31] Nursing assistants who work in nursing facilities may be offered health insurance more often than their peers in home care, but even those whose employers offer the benefit often cannot afford it. In a report based on a survey of 900 nursing assistants who work in nursing facilities, the Service Employees International Union found that 22 percent of all workers in long term care are uninsured, compared to just 14.5 percent of workers nationwide. "Close to 20 percent of CNAs surveyed don't even have access to healthcare coverage by their employer, while another 25 percent of those who are offered health plans cannot afford them," noted the report. [32]

7.4.1 Stayers and Leavers

Genevieve Gipson, the founder of Career Nurse Assistants Programs Inc. and the National Network of Career Nursing Assistants, cautions against lumping all nursing assistants together in this and other statistical analyses. At one end of the scale, she says, are those who last less than a year in the profession, increasing turnover rates and changing the overall demographic profile. At the other extreme are the veterans she calls "career nurse assistants," who stay for years and see what they do as a calling, not just a job. In their Ohio Teaching Network studies, Gipson and colleagues found that more than half the nursing assistants they surveyed had at least two years of service, just over a quarter (28 percent) had more than five, and one in eight had between 10 and 42 years. [33]

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28 American Federation of State, County and Municipal Employees. 2001. *Cheating Dignity. The Direct Care Wage Crisis in America.* AFSCME. Washington, DC.

29 Center for Workforce Studies, University of Albany, 2001 analysis of CPS data, 1997,1998, 1999.

30 GAO, May 17, 2001.

31 Wilner and Wyatt 1998.

32 Service Employees International Union (1998). A crisis for caregivers: Health insurance out of reach for nursing home workers.

33 Gipson G.A. and Garland T. N. (June 29, 1998) Final Report: Training Experienced Nurse Assistants in Long Term Care.

Maun, Lind, and Efta (2001) report a similar finding, based on consulting work done in a number of nursing facilities: "Without exception, in every client facility, we find that 60% to 80% of the staff have been there two years or longer, many since the doors opened. The other 20% to 40% fill jobs that routinely turn over five and six times per year.... Turnover rates exceeding 100% generate from as few as 20% of total positions." [34]

Although there are no national statistics on stayers, they appear to have somewhat different characteristics [35] than their shorter-term colleagues.[36] Career nursing assistants appear to be a bit older than other nursing assistants (55.9 percent are between 31 and 50). They are somewhat less likely to have gone to college, with 86.1 percent having completed their formal education at the level of high school graduation or less. As Peacock (2000) pointed out, "This profile may be an artifact of perceived or real opportunities available." [37]

Another significant difference is the stability of their primary relationships. More than half (54.3 percent) of the stayers surveyed by Gipson et al. are married, compared to less than 40 percent of all nursing assistants.

7.4.2 Strivers and Endurers

Tellis-Nayak and Tellis-Nayak (1989) proposed another way to differentiate between nursing assistants. Like Gipson and colleagues, they divided nursing assistants into two broad categories, but these categories, which the Tellis-Nayaks labeled "Strivers" and "Endurers," were based on attitude toward the job rather than years of service.[38] In the Tellis-Nayaks' estimation, nursing assistants who stay on the job for years often do so only because they cannot envision or attain a more desirable alternative.

The Tellis-Nayaks noted that all nursing assistants "share a common denominator: their socioeconomic class. They are mostly women and belong to the lowest rung of the health care labor market: they are the least educated, the least skilled, and the least paid, often barely above the minimum wage, and they endure a low occupational status. They share the lower class lifestyle, perched precariously, as most of them are, just above the poverty line, straddling that uneasy fence that separates the two lowest classes, the working class and the lower class."

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[34] Maun C., Lind D, Efta G (2001). Workforce 21: Recruitment, selection and retention of top quality staff in the 21st century. Maun-Lemke Inc. (Omaha, NE).

[35] Gipson and Garland 1998.

[36] GAO, May 17, 2001.

[37] Brian Peacock Consulting Inc. (January 2000) Recruitment, training, employment and retention: Report on certified nursing assistants in Florida's nursing homes. Florida Department of Elder Affairs (Tallahassee, FL).

[38] Tellis-Nayak, V. and Tellis-Nayak Mary (1989). Quality of care and the burden of two cultures: When the world of the nurse's aide enters the world of the nursing home. *Gerontologist* 29(3): 307-313.

But Strivers and Endurers react very differently to their shared circumstances. Strivers work hard to overcome adversity, sometimes with help from family members or others, but and always "[w]ith sheer effort, with singular determination and at a heavy price." Endurers "continue to live precariously on the edge, some caught in exploitative marriages or heartless liaisons, some as single parents valiantly seeking a better future for their children, some full of dreams but with few skills to match their hopes, and others turned cynical because, being realists, they have little hope left. Many of them had looked elsewhere for a job, but they all ended up at the nursing home. The nursing home is always short of nurse's aides."

The authors noted that no statistics clearly showed which of those types of workers predominated in nursing facilities, but added that "the data support the common impression that nursing homes hire Strivers far more than the Endurers, perhaps by a margin of 2 to 1. But because the Strivers keep their sights high, they often make up the great nursing home staff exodus. Thus, at any one time, Strivers form only a minority among the nurse's aides in a given nursing home."

7.5 The Link Between Education and Retention

7.5.1 The Importance of Turnover

The rate of turnover for this group is notorious. The lack of a standardized formula for computing turnover and retention data makes it difficult to compare data, but estimates range from 38 percent to 143 percent a year, depending on the sample studied and the method used.[39]

Some turnover among nursing assistants is inevitable—perhaps even healthy. The high rates common in nursing facilities, however, have a negative effect on residents. Constant turnover means that residents are frequently being cared for by new hires, and even seasoned nursing assistants are at a disadvantage during their first few months at a new job. The better nursing assistants know the residents they care for, the better they can identify changes in mental or physical conditions. Time on the job also allows nursing assistants and residents to develop the emotional ties that are key to residents' quality of life.

Furthermore, frequent turnover may affect the morale and workload of those who stay behind. Researcher Karl Pillemer pointed out that frequent turnover hurts morale by weakening the sense of belonging people get from "a stable group of work friends whom they know and trust," thus starting a vicious cycle. The more nursing assistants leave, "the less content are those staff persons who stay. Then these staff themselves become likely to leave. And of course, chronic staff shortages led to increased work load for nursing assistants, and more job stress." [40]

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[39] American Health Care Association (February 2001), Health Services Research and Evaluation. Staffing of nursing services in long term care: Present issues and prospects for the future. AHCA, Washington, DC.

[40] Pillemer K. The revolving door (and why it turns) (fall 1996). Journal of Long Term Care Administration. 24(3):46-9.

As Straker and Atchley (June 1999) summed up, "At the minimum, turnover affects continuity of care and care recipient relationships. In addition, staff turnover can often result in staffing shortages that require the remaining staff to do too much work in too little time."[41]

7.5.2 The Effect of Nursing Assistant Education on Turnover

Several studies indicate that education is one of several significant factors that affect nursing assistant turnover rates, although other factors are believed to have a greater influence.

High turnover rates have been linked to insufficient or ineffective orientation,[42] ineffective supervision,[43] failure to attend to nursing assistants' emotional needs,[44] strong economies that offer a variety of job opportunities,[45] and autocratic management systems that allow nursing assistants little control over their daily routines or input into resident care plans. [46-47] As a May 2001 GAO report summarizes: "The 2000 IOM study of quality in long-term care identified several environmental and job design factors that directly affect nurse aide turnover, including:

- adequacy of training;
- methods for managing workload and schedules;
- opportunities for career advancements;
- respect from administrators;
- organizational recognition;
- workloads and staffing levels;
- clarity of roles; and
- participation in decision making."[48]

As review of existing literature for a recent Pennsylvania study notes, "Training is believed to be related to turnover, but little hard data is available to support this proposition. Some studies have

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41 Straker, Jane Karnes and Atchley, Robert C. (June 1999) Recruiting and retaining frontline workers in long-term care: Usual organizational practices in Ohio. Scripps Gerontology Center, Miami University (Oxford, Ohio).

42 Tynan, C. and Witherell, J.(1984) Good orientation cuts turnover. Geriatric Nursing 5(3): 173-175.

43 Garland, N, Oyabu, N., and Gipson, G. (1989) Job Satisfaction among nurse assistants employed in nursing homes: An analysis of selected job characteristics. *Journal of Aging Studies* 3(4): 369-181.

44 Tellis-Nayak V. and Tellis-Nayak M. (1989).

45 Banaszak-Holl, Jane and Hines, M. A. (1996) Factors associated with nursing home staff turnover. *Gerontologist.* 36(4).

46 Streit, A and Brannon, D. (1994) The effect of primary nursing job design dimensions on caregiving technology and job performance in nursing homes. *Health Services Management Research*, 7: 271-278.

47 Aroskar, Mila Ann; Urv-Wong, E.K. and Kane, R.A. (1990) Building an Effective Caregiving Staff: Transforming the Nursing Service in Kane,R. and Caplan, A.L. (eds.) *Everyday Ethics: Resolving Dilemmas in Nursing Home Life.* New York: Springer Publishing.

48 GAO, May 17, 2001.

found that training programs in nursing homes did not have much of an effect on the performance by nurse aides." [49-50] However, the researchers found a strong relationship between retention rates and the number of hours of training provided, supporting "the idea that more training has a positive effect on retention."

Another study of nursing assistants in two nursing facilities found that those who were assigned at random to an educational program on dementia care had lower turnover rates at three months and six months after the training than the control group. The researchers posited that the CNAs who attended the classes may have felt more empowered and better able to communicate with the residents they cared for.[51]

But the strongest link between turnover rates and education does not appear to be what nursing assistants are taught. Instead, it may be what they are *not* taught. Crucial skills such as critical thinking and time management are rarely covered in class (see Section 7.12). Little or no time is typically spent on teaching how to communicate with people with dementia, although 70.9 percent of all nursing facility residents have long-term and/or short-term memory problems, 72.9 percent have problems with orientation, and the ability to make daily decisions is impaired or severely impaired in 80.6 percent.[52] And regardless of what is taught in class, newly minted nursing assistants generally find that getting things done takes precedence over doing them right.

With one nursing assistant commonly responsible for nine or more residents on the day shift and twice as many at night,[53] time management often degenerates into triage. Baths and meals are given on a tight schedule and at the convenience of the home's routine rather than the residents, leading to things like waking residents in the middle of the night for showers. Call lights are left unanswered, nonessential tasks such as nail care are neglected, and practices are often adopted that endanger either residents or staff.[54]

"The training I got had a lot of good ideas," said nursing assistant Shirley Rosser.[55] "Some I still think about, especially ways of lifting, universal precautions, things that are not really hands-on

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49 Brannon D. and Smyer M.A. (1994) Good work and good caring in nursing homes. *Generations* 18:34-38.

50 Smyer M., Brannon D. and Cohn M. (1992) Improving nursing home care through training and job redesign. *Gerontologist* 32: 327-333.

51 McMallion P et al. (1999) Educating nursing assistants to communicate more effectively with nursing home residents with dementia." *Gerontologist* 39(3): 546-558.

52 Krauss MA and Altman BM. Characteristics of Nursing Home Residents—1996. Agency for Healthcare Policy and Research 1998, MEPS Research Findings No. 5, AHCPR Publication No. 99-0006 (Rockwell, MD).

53 Stakeholder perceptions of appropriate nursing home minimum staffing: Report on focus groups with nurse aides (Summer 2000). Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Volume I, Chapter 5. Health Care Financing Administration, Washington, DC.

54 Bowers and Becker 1992.

55 Personal communication.

care. When it comes to that, you are too busy to 'do it right'; you just need to get it done. Isn't that a shame, to treat our residents like that? Yet it is the only way to get done before the end of the shift."

Researcher Karl Pillemer found that 40 to 50 percent of all nursing assistants leave during orientation and training,[56] often because they don't know where to turn for help in prioritizing a competing list of demands. "Frustration with their inability to get everything done leads to low self-esteem, high stress levels and disillusionment with their job," he wrote. "The new CNA graduates generally have not had enough experience to gain good organizational, prioritizing, and time management skills."

Robert Atchley reported similar findings. "Nursing home workers often quit early in their tenure, some in response to the heavy demands of the job, some to pursue better opportunities, and some from disillusionment caused by the gap between when they saw as the ideal of frontline care and the realities of work in many nursing homes," he wrote.[57] "Of course," he added, "others leave because they do not like the work or are discharged because they are not doing an adequate job."

For those who stay, a lack of time management skills may lead to inadequate care, according to one study of nurses' perceptions of the role played by nursing assistants. One contributor to poor care, they said, was that "nurse assistants often do not receive enough practical experience in their training and are therefore too frequently ill-prepared for 'real world' conditions."[58]

7.6 The History of Current Educational Requirements

7.6.1 1986 IOM Study and the History Behind OBRA 87

Prior to the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), there were no federal requirements concerning the qualifications of nursing assistants.

A 1986 study by the Institute of Medicine [59] found that nursing assistants provided approximately 90 percent of the care received by nursing home residents, and that federal regulations allowed nursing assistants to deliver care without the supervision of a registered, licensed, or vocational nurse from 3 p.m. to 7 a.m. Yet these key caregivers were generally inexperienced and inadequately trained to perform their duties.

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[56] Pillemer (Fall 1996).

[57] Atchley, Robert C. Frontline workers in long term care: Recruitment, retention, and turnover issues in an era of rapid growth. Scripps Gerontology Center, Miami University (Oxford, OH), September 1996.

[58] Shirm, V and Garland, T.N. (1997) Nurses' Perceptions of the role of nurse assistants in delivery of quality care in the nursing home. Presented at the annual meeting of the Midwest Sociological Society, Des Moines, Iowa, April 3-6, 1997.

[59] Institute of Medicine, Committee on Nursing Home Regulation. 1986. *Improving the Quality of Care In Nursing Homes*. Washington, D.C.: National Academy Press.

The study reported that only one-third of the states (17) mandated training programs for nursing assistants, and their requirements varied widely. Some required only 20 hours, while others required 150, comprised of 50 hours of classroom and 100 of clinical training. There was no consistency in format or course content.

The study's recommendations, which provided the basis for much of OBRA 87, included a call for federal standards for nursing assistant training. IOM recommended that, as part of the administration conditions of participation in Medicare or Medicaid, nursing homes must employ only nursing assistants who have completed a state-approved training program in a state–accredited institution such as a community college.

Federal regulations

The federal regulations concerning certification training for nursing assistants address virtually all aspects of administration and testing of the programs. They do not contain instructor-to-student ratios, but some states have established these ratios on their own. In addition, many states have increased the minimum number of training hours. California, for instance, requires at least 150 hours of training

The provisions of the OBRA '87 [60] legislation were implemented through regulations and guidelines. The Social Security Act added new provisions relating to nurse aide competency evaluation programs (CEPs) and nurse aide training and competency evaluation programs (NATCEPs). Sections 1819(b)(5), 1819(e)(1), and 1819(f)(2), 1919(b)(5), 1919(e)(1), and 1919(f)(2) of the Act established the following:

- Facilities participating in Medicare and Medicaid may not employ anyone as a nursing assistant for more than four months unless the individual has completed a NATCEP or a CEP approved by the state and is competent to provide such services.

- The Secretary must establish standards for the training and competency evaluation of nurse aides.

- States may approve only of CEPs and NATCEPs that met the standards established by the Secretary.

- States may not approve a program offered by or in a nursing facility that has been determined to be out of compliance with federal long-term care facility requirements within the previous two years.

- Facilities may not employ temporary nursing assistants who have not completed a NATCEP or CEP approved by the state.

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[60] Federal Register 42CFR Part 431 et al. *Medicare and Medicaid; Requirements for Long Term Care Facilities; Final Rule* 56(187): September 26, 1991

Federal regulations established basic curriculum requirements for a nursing assistant training program.[61] While states and individual instructors were welcome to include more, they were required to include the following:

- At least 16 hours of training prior to any direct contact with a resident, which must incorporate
  --communication and interpersonal skills
  --infection control
  --safety and emergency procedures, including the Heimlich maneuver
  --promoting residents' independence
  --respecting resident's rights.
- Basic nursing skills, including
  --taking and recording vital signs
  --measuring and recording height and weight
  --caring for the residents' environment
  --recognizing abnormal changes in body functioning
  --reporting such changes to a supervisor
  --caring for residents when death is imminent.
- Personal care skills, including
  --bathing
  --grooming, including mouth care
  --dressing
  --toileting
  --assisting with eating and hydration
  --proper feeding techniques
  --skin care
  --transfers, positioning, and turning.
- Mental health and social service needs, including
  --modifying one's own behavior in response to residents' behavior
  --awareness of developmental tasks associated with the aging process
  --allowing residents to make personal choices
  --providing and reinforcing other behavior consistent with the resident's dignity
  --using the resident's family as a source of emotional support.
- Care of cognitively impaired residents, including
  --techniques for addressing the needs and behaviors of individual with Alzheimer's disease and other dementias
  --communicating with cognitively impaired residents
  --understanding the behavior of cognitively impaired residents
  --appropriate responses to the behavior of cognitively impaired residents
  --methods of reducing the effects of cognitive impairments.

[61] Federal Regulations, Title 42, Part 483, Subpart D, Section 483.152

- Basic restorative services, including
  --training residents in self care to the fullest extent possible
  --use of assistive devices in transferring, ambulation, eating, and dressing
  --maintaining residents/ range of motion
  --proper turning and positioning in bed and chair
  --bowel and bladder training
  --care and use of prosthetic and orthotic devices.
- Residents' rights, including
  --providing privacy and maintaining confidentiality
  --promoting the residents' right to make personal choices to accommodate their needs
  --giving assistance in resolving grievances and disputes
  --providing needed assistance in participating in resident and family groups and other activities
  --maintaining care and security of residents' personal possessions
  --promoting the resident's right to be free from abuse, mistreatment, and neglect
  --reporting instances of such treatment to appropriate facility staff
  --avoiding the need for restraints in accordance with current professional standards.

Section 483.152 also specifies who must pay for nursing assistant training, stating the following: "(1) No nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program may be charged for any portion of the program (including any fees for textbooks or other required course materials).

(2) If an individual who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility not later than 12 months after completing a nurse aide training and competency evaluation program, the State must provide for the reimbursement of costs incurred in completing the program on a pro rata basis during the period in which the individual is employed as a nurse aide."

Finally, federal regulations[62] establish the following guidelines for state approval of a NATCEP or CEP:

- The state must respond to a request for approval within 90 days.
- The state must make at least one on-site visit to the entity providing the training or performing the competency evaluation.
- State approval of a program is granted for a two-year period.
- A program must consist of no less than 75 hours of training and include at least 16 hours of supervised practical training. Practical training is defined as training in a

[62] Federal Register 42CFR Part 431 et al. *Medicare and Medicaid; Requirements for Long Term Care Facilities; Final Rule* 56(187): September 26, 1991

clinical setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse (RN) or a licensed practical nurse (LPN).

- Training must be performed by, or under the general supervision of, an RN who has a minimum two years of nursing experience, at least one year of which must be in the provision of long-term care services. In a facility-based program, that function may be performed by the director of nursing.

- A NATCEP must employ the competency evaluation procedures specified in 483.154, which details such matters as how the evaluation must address each course requirement listed above and the importance of using a system that prevents disclosure of the answers.

Why current educational requirements may not be sufficient

As was the case when IOM published its 1986 study, CNAs continue to provide approximately 90 percent of the care to nursing home residents. In the past 15 years, however, the average acuity level of nursing home residents has risen, requiring nursing assistants to deliver more complex care. Yet the training provided to CNAs has not changed with this change in resident acuity.

In addition, there is little consistency nationwide in the content of nursing assistant training programs or the number of hours of certification training required, although these programs appear to meet federal requirements. In-services and other educational programs also vary widely in content and format.

Finally, there is growing evidence that the minimum federal requirements may not be adequate to meet the educational needs of nursing assistants. More hours of certification training and a greater focus on orientation for new workers and supervision and ongoing education for both new and experienced CNAs may be needed to prepare nursing assistants for the complex demands of their job.

7.7 Effective Teaching Methods

7.7.1 How Nursing Assistants Learn Job Skills

Nursing assistants value their formal educations. Shirm et al. (2000) noted that "many nursing assistants felt there is no substitute for experience in learning how best to meet residents' needs, [but] they also frequently commented that formal training was necessary for learning how to provide good care."[63] Deutschmann (2001) asked nursing facility administrators, directors of nursing, nursing assistants, social workers, family members and surveyors about obstacles to

[63] Schirm, Victoria, Albanese, Terry, Garland, T. Neal, Gipson, Genevieve and Blackmon, Dorothy J. (August 2000) Caregiving in nursing homes. *Clinical Nursing Research*, 9(3): 280-297.

quality care. When asked to name opportunities for change, "Training, orientation or education" tied for first place, mentioned by more respondents than anything else other than "improve communication." [64]

Yet their formal training and education receives poor marks from many nursing assistants. In a 1998 study of nursing assistants, 86 percent of the respondents rated education and training to do their job better as "very important," but more than a third (37 percent) said their training had not prepared them to do the job well. As one said: "I figure a lot out on my own because of my background, but I feel all of us would benefit from timely and complete training at the beginning of our employment."[65]

To be effective, "timely and complete" training must not be limited to the classroom. Classroom teaching, noted Robert Atchley in a 1996 study, "is often negatively evaluated by frontline workers in long-term care, often because it is either 'above their heads' or has no obvious application in their everyday work."[66] Respondents to the Iowa Caregivers Association's focus groups echoed that sentiment, and most agreed that the best way to learn skills was "by being shown what to do, and then practicing 'hands on' until they can perform comfortably by themselves."[67]

In a survey of nursing assistants with relatively long job tenures, Gipson et al (August 1998) found that many of the tasks they considered very important and/or did every day were learned on their own or from others on the job rather than in formal training. These included the following:

- Learn how to train a new nurse assistant (22 percent self-taught; 58 percent taught on the job);
- Check and report on the condition of a resident's skin (20 percent self-taught; more than 50 percent taught on the job);
- Communicate about a resident's condition or behavior to other members of the staff (28 percent self taught; 49 percent taught on the job); and
- Position resident properly in bed (9 percent self-taught; 60 percent taught on the job). [68]

Nursing assistants also teach one another how to do things—not always correctly. "New [nursing assistants] are sometimes berated [by their experienced coworkers] for doing things the right way

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64 Deutschmann, Marian (August 2001).

65 Hill Simonton Bell, LC. (December 1998) Certified nursing assistant (CNA) recruitment and retention pilot project. Phase I: Survey results. Iowa Caregivers Association.

66 Atchley 1996.

67 Hill Simonton Bell, LC. (January 1999) Certified nursing assistant (CNA) recruitment and retention pilot project. Phase II: Focus group study results. Iowa Caregivers Association.

68 Gipson, G, Garland, RN and Benedict L (August 1998). Training experienced nursing assistants in long term care: A research report submitted to the National Institute on Aging, Washington, DC.

and not taking shortcuts," points out nursing assistant educator Barbara Acello. "Many cannot resist the peer pressure and do not stand their ground, so they develop sloppy work habits."[69] Researcher Marian Deutschman makes a similar point. "Newcomers learn appropriate (and sometimes inappropriate) behaviors by listening to stories and anecdotes, hearing about rituals and observing the nonverbal behaviors or their peers and supervisors,"[70] she writes.

To reinforce good work habits on the job, some providers combine formal training with formalized, institutionally supported peer supervision. Robert Atchley believes that combination can be powerful. "[T]raining that emphasizes classroom formats is not nearly as effective as a model that uses senior 'master CNAs' to work alongside frontline staff, model effective job performance, and train CNAs as they go," he says. "In this latter context, material is introduced when it is most relevant and is not disconnected from the activities of the job. Of course, the master CNAs themselves must be trained to be trainers."[71]

After researching current methods of training nursing assistants, Kramer and Smith (May 2000) concluded that one of the most effective was "a model which could perhaps best be described as 'peer-oriented,' with the focus on nursing assistants teaching and sharing with each other."[72] That method shows promise, they wrote, because it allows nursing assistants to benefit from each other's "valuable and extensive knowledge base." The researchers believed that nursing assistants would be more receptive to information and ideas emanating from their peers, more likely to implement them, and perhaps even inclined to "encourage their use and implementation among one another."

The Cooperative Healthcare Network (CHCN), a group of five agencies and training programs for direct care workers, has documented several essential elements of effective training based on 15 years of experience. Prominent features of the CHCN training program include peer support groups for new workers led by former nursing assistants and a coaching style of supervision, which builds a positive relationship between nursing assistants and their supervisors and encourages nursing assistants to develop and use problem-solving skills while maintaining high standards of care. Although most CHCN providers work with home health aides, the network's approach to training can be applied to preparing direct care workers in any setting. (For details, see Sections 7.7.2 and 7.16.2.)

Peer support groups have also proven effective. In a study of support groups for nursing assistants led by a skilled facilitator in 16 Massachusetts nursing facilities, Wilner and

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69 Personal communication.

70 Deutschman Marian. (June 2000) "What you hear when you listen to staff," Nursing Homes Long Term Care Management.

71 Personal communication.

72 Kramer, N.A. and Smith, M.C. (May 2000). The Effectiveness of a peer-oriented, work-integration dementia care training program for nursing assistants: Final report. New York State Department of Health Dementia Project.

Shenkman (1993) reported: "Participation in the groups helped nursing assistants to work better as a team, to learn from one another, and to develop new skills of coping, communication and problem solving as well as to carry those back to their responsibilities on the floor. Nursing assistants also enhanced their [feelings] of self-confidence." [73] Participants who had difficulties with English used the sessions to practice and improve their English language skills. Others reported learning more about teamwork, how to communicate with peers and supervisors, and how to express themselves more effectively. This ability to communicate better also helped reduce their stress on the floor. "Learning how to communicate... eased some of the tension," said one participant. "It also made me feel important because people took the time to listen to you," said another. In addition, learning emerged from the exchange of technical information about resident care and from practicing skills of communication and problem solving through the group interaction.

Long term care employers in the Pioneer Network, a national organization dedicated to changing the culture of aging in America, have designed training programs and a supportive workplace culture that is based on Network and individual organization values. Several of these employers, including Apple Health Care and Providence Mount St. Vincent, are highlighted in more detail throughout this chapter.

From the first day of work, the training emphasis at Network member facilities is on skill building to enter into a caregiving relationship. Tasks are de-emphasized. For example, CNAs are taught to get to know an individual, learn their bathing habits and incorporate this information into the bathing experience the resident will be offered in the nursing home. Nursing assistants enter into relationships with a primary group of residents whom they always care for, so the CNA knows those residents are looking forward to seeing her, depending on her not only for care tasks but for the fact that she knows each resident personally and brings that knowledge into the care. Pioneers seek to engage both elders and experienced CNAs in the training process. Learning from residents directly, and from peers who experience the challenges CNAs face daily, is more effective than being taught by a nurse alone.

Many Pioneer organizations offer their own CNA certification courses. Although state and federal requirements are met with regard to the minimum certification standards, many add communication and on-the-job training. In addition, the Network strongly encourages career ladder opportunities, which enable a CNA to grow within the career of CNA, advancing both job responsibilities and wages. (For more on career ladders, see Section 7.13.)

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[73] Wilner, M.A. and Shenkman S (1993). *Evaluation of Nursing Assistant Support Groups in Nursing Homes.* Final Report to National Center for Nursing Research of the National Institutes of Health (Washington, DC).

7.7.2 Adult Learning Methods

Research shows that not everyone learns in the same way. [74-75] While some easily absorb information delivered in lectures or books, others tend to tune out a barrage of written or spoken words. In fact, according to researcher David Lazear, everyone learns in multiple ways.

Lazear (1991) divided adult methods of learning into seven types: verbal-linguistic, visual-spatial, logical-mathematical, kinesthetic, musical-rhythmic, interpersonal, intrapersonal, and natural awareness.[76] To teach a group of adults incorporating various styles of learning, he argued, educators must use a variety of teaching styles, including demonstrations and role playing for the kinesthetic learners, graphics for the visual learners, repetition or rhyme for the musical-rhythmic learners, and so on.

These methods need not replace the traditional lecture. Instead, they can augment it. As one recent paper put it, a lecture is the most effective way of teaching "as long as it is well structured, clearly presented and uses the full range of techniques and visual aids available."[77]

In addition to differing ways of learning, adult learners have previous life and work experience that may affect the way they process new information. Phillips and Baldwin (1997) noted that nursing facility nursing assistants tend to be older than their peers in acute care and have a significant amount of work experience. As a result, they concluded, "New information must be incorporated into existing knowledge and ideas." This could be done most effectively, they said, through adult learning methods such as videotaping and then analyzing role-plays, or introducing a new topic by discussing related experiences that the students have had. [78]

Nursing assistant educators often incorporate devices such as role playing and sensory deprivation exercises into nursing assistant training programs, but the success of such methods varies depending on the educator's charisma and energy level and the extent of his or her formal training in how to teach adults. The biggest hurdle to implementing these innovations may be simply finding the time to fit them in. "We teach the traditional way—lecture and lab in the classroom, 24 hours of clinical," said one nursing assistant educator of the certification training she offers. "We try to be as innovative as possible with creative teaching techniques, but it is a

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74 Kolb, D. (1987) "The process of experiential learning," *Culture and Processes of Adult Learning.* London: Routledge.

75 Anderson, J. and Adams, M. (1992) "Acknowledging the learning styles of diverse student populations: Implications for instructional design" Teaching for Diversity, 49:23.

76 Lazear, D. (1991) Seven ways of knowing: Teaching to multiple intelligences. Skylight Publishing (Palatine, IL).

77 Adcock, Lesley. (July 2000) Linking basic theory to practice for healthcare assistants. *Journal of Community Nursing.*

78 Phillips R and Baldwin BA (Mary/June 1997). Teaching psychosocial care to long-term care nursing assistants. Journal of Continuing Education in Nursing 28(3): 130-134

vast amount of material to cover in a very short time." [79]

The Cooperative Healthcare Network uses a four-to five-week program to educate its direct care workers, most of whom are home health aides. The program is based on the philosophy that, while adults often resist formal education, everyone continues to learn and incorporate new knowledge throughout their lives. This may be especially true of new recruits to nursing facilities, who may have poor histories in the formal educational system. For details on the CHCN training program, which incorporates various adult teaching techniques, see Section 7.16.

7.8 Certification Education and Testing

7.8.1 What Gets Taught in Certification Classes

The curriculum varies dramatically from state to state. Some mandate only the 75-hour federal minimum of classroom or supervised lab time and require no clinical experience in a nursing home, while others require much more. (For details, see Section 7.6.1.)

Instructors are free to teach more than the mandated minimum, and many do. Certain types of providers may also offer more than others, on average. A Pennsylvania study found that government-operated nursing facilities provided an average of 105 hours of formal education, while privately operated facilities averaged 78 hours.[80]

Clinical experience is not required in every state. In fact, some states forbid it. Student nursing assistants in Oregon aren't allowed any hands-on experience until they've finished their certification classes, says Oregon-based researcher Joanne Rader. "If these people don't have any [clinical] experience, nothing that's said in the classroom really makes any sense," she notes.[81]

There may also be some disconnect between what students are taught in certification classes and what they do on the job. In Oregon, Rader points out, students must learn how to use physical restraints, although most facilities in the state don't use them any more."

7.8.2 The Basic Curriculum

At its most basic, the material covers just 75 hours. At least 16 hours must consist of practical training supervised by a registered nurse or licensed practical nurse.

In Texas, which one nursing assistant educator describes as fairly typical of states that require only 75 hours, the mandated material is divided into five sections. Those sections may be taught in any order, but the material within each section must be taught as a unit.

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[79] Personal communication

[80] Pennsylvania's Frontline Workers, February 2001

[81] Personal communication

Section One includes the 16 hours on specific topics that OBRA says must be taught before students may have any contact with nursing facility residents. It introduces all the major topics, starting with an overview of nursing facility residents; the nursing assistant's role; communication and interpersonal skills; and good work habits. It covers resident rights and other OBRA regulations, as well as other laws that apply to nursing facilities, such as the Safe Medical Device Act and accident and incident reporting. It touches on infection control and basic nursing skills. It addresses personal care — both attending to one's own physical and mental health and helping residents with bathing, toileting, mouth care and other personal care needs. It covers mental health and social service skills; basic restorative care; and care for the cognitively impaired. It covers creating a safe environment, including fall prevention and what to do in case of a fall, a seizure, vomiting, or choking; and what to do in case of fire or a natural disaster.

Federal law mandates that the Heimlich maneuver must be taught, but CPR generally is not — perhaps because there's no time to fit it in. "This is intense stuff you're squeezing into those 16 hours," points out a nursing assistant educator.

Section Two focuses on delivering personal care to residents, covering grooming, bathing, transfers, positioning, nail care, incontinence and perineal care, nutrition and hydration, care of the resident's environment, oral hygiene and more. Texas requires that 17 hours be spent on this section.

Section Three covers basic nursing skills. Included are measuring and recording blood pressure and other vital signs, use of restraints, measuring height and weight, care of the dead and dying, and procedures for admission, transfer, and discharge. Students are also taught observation skills and told how to report and chart treatments and changes in resident status. This section must last at least eight hours.

Section Four covers restorative care, including range of motion, ambulation, assisting residents with adaptive or assistive devices and prostheses, and more. This section is important, points out Acello, because "the OBRA requirements are all about maintaining and improving resident functioning, and that's what restorative care is all about." Texas requires at least four hours of training in this area.

Section Five, which encompasses mental health and social services, covers Abraham Maslow's hierarchy of needs, the losses nursing facility residents commonly experience, how to cope with their problematic behaviors, and information about aging, residents' coping and defense mechanisms, and dementia and other cognitive losses. Texas mandates six hours to cover that material.

7.8.3 Going Beyond the Basics

Texas educators say the curriculum is difficult to cover in just two weeks. One instructor says her community college program includes 144 classroom and 64 clinical hours. The additional hours,

she says, give her a chance to get into "critical thinking skills. Instead of just giving a bath, we're really looking at the individual." [82]

The extra time also allows her instructors to teach the crucial communications aspect of care more effectively, even role-playing how to make small talk with residents. "Students go into the clinical scared; they don't know how to start a conversation with someone they don't know," she says. It gives instructors time to explain not just what nursing assistants should do but why. And, she says, because her students understand why it's important to do things like wash their hands and dress neatly, they're still doing those things on the job years later.

Other states routinely offer considerably more than 75 hours of training. In Florida, for instance, the minimum number of hours is 120, but programs may last up to three times that long. Private training programs in the state averaged 259.5 hours in 1997-98. [83]

7.8.4 Who Develops the Curriculum

Each state appoints a regulatory body — often the state board of nursing or health department, but sometimes an independent contractor — to develop its guidelines. Sometimes the governing body writes the guidelines, but more often it convenes a group of RNs and other experts to create them. The group may also create a curriculum or approve the use of an existing curriculum.

Nursing assistants are virtually never asked for input into these curricula. One review of programs found that almost all "take their ideas, information, and principles of care from the work of various health care professions, but not from nursing assistants."[84]

Many educators follow a curriculum developed by the Red Cross. Others use the ProCare curriculum. ProCare was developed in 1988 for the American Health Care Association by Educational Testing Service and Professional Training Systems, Inc., with input from long term care providers, health care educators, state regulators, consumer advocates, and others.

7.8.5 How the Curriculum is Taught

Certification training is usually delivered through a combination of lectures, discussions, videotapes, and supervised hands-on practice. Students typically practice on one another in the classroom, though many states or individual schools also require clinical practice in a nursing facility as part of the curriculum.

Educators may use textbooks, educational CD-ROMs or videotapes to augment their lectures. They may bring in guest lecturers who are expert on a particular subject. They may also use

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82 Personal communication.

83 Brian Peacock Consulting Inc., January 2000.

84 Kramer, N. and Smith, M. (2000) Training nursing assistants to care for nursing home residents with dementia, in V. Molinari (Ed.), *Professional psychology in long term care*, NY: Hatherleigh.

tactics such as empathy training, in which students are temporarily "handicapped," often with a blindfold, to get a sense of how it feels to live with a disability.

But the traditional style of teaching predominates. "Almost all the manuals and videotapes use a primarily didactic style in which informational material is presented via readings, videotapes, or lectures and the nursing assistant is a passive recipient, expected to maintain close attention and understand and absorb the lesson," writes Kramer. [85] Some programs "incorporate other teaching styles to a significant degree, including discussion, role-playing or other exercises, and on-the-job training," she notes, but only a few use non-didactic styles as their main method of teaching.

Most teaching tends to be "very task-oriented: 'This is how you wash your hands,'" as one educator puts it.[86]

7.8.6 Teacher Training and Supervision

Federal law requires only that the teaching be "performed by or under the general supervision of a registered nurse who possesses a minimum of two years of nursing experience," at least one of them in long term care.[87] Some states require that all instructors be registered nurses, but others allow LPNs to teach, as long as an RN is in charge of the program.

The federal requirements for instructors' educational backgrounds are loose, requiring teachers only to "have completed a course in teaching adults or have experience in teaching adults or supervising nurse aides."[88] Although many states mandate train-the-trainer preparation, these standards are rarely rigorous either. Ohio, for example, requires only that educators attend 28 hours of classes, which cover state laws and standards, resident and nursing assistant demographics, and training in how to use audiovisual equipment.[89] Any other professional who may teach part of the nursing assistant course, such as a pharmacist, dietitian, fireman, or gerontologist, is required only to have at least one year of experience in his or her field.

As one study sums it up: "[T]he persons responsible for training new workers too often lack formal education and may have only a few months more experience than the persons being trained."[90]

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85 Kramer and Smith, 2000.

86 Personal communication.

87 Federal Regulations, Title 42, Part 483, Subpart D, Section 483.152 (a)(5)(i).

88 Federal Regulations, Title 42, Part 483, Subpart D, Section 483.152 (a)(5)(ii).

89 Personal communication, Genevieve Gipson.

90 Jacobs, H. (January 22, 1994) A new development in the education of direct care practitioners. SUNY-New Paltz.

7.8.7 Where Classes are Held

Classes are usually provided by nursing facilities, private schools, vocational-technical schools, or community colleges. Some high schools offer nursing assistant courses as part of their curriculum. Students who don't attend class at a nursing facility usually spend some time in one for clinical training.

A group of nursing assistants polled in 1988 cited pros and cons for each type of location. Nursing facilities, they pointed out, give students hands-on experience with residents and a more realistic sense of how to handle a typical day's work. However, they said, the quality of instruction varies widely, with good facilities providing good educations and inadequate facilities providing bad ones. Community colleges and vocational-technical schools are more closely monitored for quality, but they may lack the crucial clinical component. Private, for-profit programs elicited the most criticism, with respondents reporting that some charged "exorbitant fees," prepared students poorly, and made false promises about employment opportunities after graduation.[91]

Others contend that the quality of instruction is usually better in licensed schools, pointing out that they are held accountable by the state for the quality of their instructors and instruction, while nursing facilities are not. Furthermore, students taught in nursing facilities may be taken out of class to help care for residents. "If [the facility is] short-staffed, students are pulled to the floor but given credit as if they were in the classroom," says one nursing assistant educator. [92]

Castle (2000) found that nursing facilities that provide their own certification training had fewer survey citations for excessive restraint use than facilities that did not do their own training. However, the author cautioned, there may not be a causal relationship between the training and the lower citation rate. Facilities that offered their own training, he hypothesized, may simply be more sophisticated than their peers, and hence likelier to be aware of the need to reduce restraint use. [93]

Facility-based classes are common in most areas, but government officials sometimes prohibit it. No training offered by a facility in Florida or the District of Columbia, for instance, is approved by the state unless the facility is licensed as a school. And in all states, OBRA will not allow a nursing facility to provide certification training and testing if, within the past two years, it has been cited for immediate jeopardy or certain other types of substandard care on an annual survey.

In some cases, facilities band together to train each other's workers. Seattle-based Providence Mount St. Vincent nursing home, for example, trains nursing assistants for nearby rural

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91 National Citizens' Coalition for Nursing Home Reform (January 30, 1988). Final report: Nurse aide training symposium. NCCNHR, Washington, D.C.

92 Personal communication.

93 Castle, N (2000). Deficiency citations for physical restraint use in nursing homes. Journal of Gerontology 55B(1): 533-540.

facilities that do not have the resources to do their own training. (For details, see 15.2.1) An innovative partnership has developed in Tucson, where the Direct Caregiver Association (DCGA) is bringing together healthcare providers, workers and others to address the caregiver shortage by recruiting, training and retaining caregivers. A nonprofit entity developed by a local home care agency, DCGA trains home health aides not just for its parent agency but for other home health and nursing home providers throughout Tucson. In addition, it operates a resource center that offers career counseling, training, continuing education and professional development to both individuals and organizations providing long-term care.

7.8.8 Certification Testing

> *"In Maryland, individuals who want to become groomers and handlers of dogs must have a seven-week course (for poodles) or a 14-week course for all breeds ... To deny long-term care workers quality training is insulting to them and those they care for."*[94]

The test consists of two parts, a competency evaluation and a skills demonstration. For the competency portion, the student is allowed to choose either a written or an oral exam, allowing students with poor or no literacy skills to pass. In many states, including Texas, Florida and New Mexico, students may opt to take the oral test in Spanish.

Some states have developed their own tests, while others use a test developed by the Red Cross. A handful use a test by D&S Diversified Technologies. About two-thirds use at least part of the Assessment Services International (ASI) test, some pairing the competency part of ASI's test with a skills test of their own.

The written examination of the ASI test consists of 10 pre-test questions and 60 that are scored. To pass, a candidate must get approximately 80 percent of the scored questions right. To pass the skills test, the candidate must get all the critical element steps correct, along with about 80 percent of the remaining steps within each set of five skills demonstrated.

7.8.9 Pass Rates

While the test inspires dread in nearly all who take it, the great majority pass—although some fail once or twice before succeeding. In Texas, for instance, where the test is given in three different forms, 80 percent of those tested in 2000 passed the written English version, 65.9 percent the oral English, and 52 percent the oral Spanish. And in Florida, the pass rate was 88 percent for all candidates tested during the year starting on July 1, 1997.

Some nursing assistants fault the test for being too easy, too far removed from the skills needed to do the job well. Her own test, notes nursing assistant Patricia Green, was "scary but, in hindsight, stupid.... I was observed doing tasks only. I was told to give a bed bath; I did so. I was

[94] Holder, Elma. Paraprofessionals on the front lines: Improving their jobs—improving the quality of long term care. AARP symposium panel, September 10-11, 1998.

told to do a set of [vital signs]. Again I did so. Not once was I asked to deal with a demented lady who was having a hard time. Not once was I presented with a hypothetical situation [and asked to] verbalize how I would act." [95]

Others complain that the test is too arbitrary. Because each state's tests are developed and administered by a different group than its certification curriculum, the two don't always cover the same ground, and even the best students may fail if they are tested on material they haven't been taught.

7.8.10 Who Gives and Evaluates Tests

Each state appoints a governing body to oversee the test. This is not the same group that oversees the certification curriculum.

The testers are often the same people who teach the certification curriculum. According to federal law, a nursing facility employee may proctor the test of one of the home's own students, but someone else must evaluate and score the test.

7.8.11 "Testing Out"

A clause in the federal regulations allows a nursing assistant to become certified without taking classes if he or she can pass the test. In most states, this is a rare occasion. "I don't think someone right off the street could walk in and pass," notes Acello, who teaches in Texas and corresponds with nursing assistant educators nationwide. Those who succeed, she adds, are generally nursing students who want to work as nursing assistants while completing their educations, or former nursing assistants who want to get back on the OBRA-mandated registry of certified and otherwise eligible nursing assistants maintained by each state.[96]

In at least one state, however, there is considerable disagreement over whether candidates should be allowed to take the test if they have not attended an accredited training program. In Florida, this practice is called "challenging the test," and it is relatively common. Challengers may be certified CNAs who have moved to Florida from another state, people in an approved program who want to take the test before completing the program, or people with related work experience who think they can pass without going through nursing assistant training. In many cases, however, they come from a fourth category: people who attended a training course that was held by one of the state's nursing facilities. Such courses are not approved by the state department of education, which oversees certification training in Florida.

Many managers of nursing facilities say they wouldn't have enough good candidates if they relied only on state-approved private schools to supply them. However, as Peacock (2000) noted, "There is substantial division on this issue. Those associated with approved training programs

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[95] Personal communication.

[96] Personal communication.

view the challenge as a threat to the quality of care that CNAs provide (due to inadequate training)." [97]

7.9 Transferring Learning to the Work Site

> *"My vision is to be able to walk into work and see enough well-trained and experienced CNAs to finally give QUALITY CARE to our residents! The present conditions for most of us CNAs prevent us from ever being truly well trained! Why? ...[W]e have to skip many steps that should be done just so we can accomplish minimal standards of care! ... Even if we did take and pass all the courses offered us, most of it would be a wasted effort because we could never practice what we learned! Now if we were offered a raise or some sort of bonus for achieving advanced goals and skills? Why not? I would do it! But we don't.*
>
> *"These courses would be taught where? At the facility? Cool, but what about working? Oh! On our days off, or we should come in early before work so we could take them? Ok, I will give up my valuable time for a few courses. What? We can't practice what we learned because we have not enough staff? What a surprise! What? Over half the people that showed up for class were pressed into work instead? Wow! What a surprise.... Good ideas are easy to come by. Good conditions to carry them out are very rare to come by."*[98]

As discussed in Section 7.5.2, the gap between what is taught in certification classes and what nursing assistants learn on the job can be wide. Due to a lack of effective orientation or supervision, newly minted nursing assistants are often left to bridge that gap as best they can. "I know a lot of NAs who feel competent but don't feel confident," says Genevieve Gipson. "They're always scared. I think part of what's going on is that they never get any effective feedback. They're never really sure they are doing things right."[99]

7.9.1 Orientation

Orienting a new worker to the job takes time. "A good manager knows that an orientation period should last more than a few shifts," notes nursing assistant Patricia Green. "Orientation needs to cover everything from policies to who to call to what to do in an emergency."[100]

In a paper describing the Pioneer Network's philosophy about relationships between residents and workers in nursing facilities, social worker Carter Catlett Williams wrote: "the orientation

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97 Brian Peacock Consulting Inc., January 2000.

98 Message posted by CNA Richard J. Solka to the NursingAssistant@yahoogroups.com listserv.

99 Personal communication.

100 Personal communication.

can be an opportunity to introduce the new staff member into a team which is characterized by mutual support, good communication and a sense of learning together." [101]

New nursing assistants are not the only ones who need orientation. In Pennsylvania's recent study of nursing assistants, respondents pointed out that orientation "isn't just when you first start in this profession. It's anytime your situation or work environment changes. For example, if you are working in a nursing facility and you are going to move to another wing or hall, you should have an orientation period to get to know the residents, their needs, specific issues, and so on."[102]

The need for this kind of apprenticeship is generally accepted for other healthcare workers. Nurses, for instance, work under close supervision for their first months on the floor and perform only limited duties at first. Yet nursing assistants are usually expected to assume a full patient load and a full set of duties from the start, and they are generally given little guidance.

Orientation in most facilities is restricted to new hires--and even for them, it ends quickly. In a study of nursing assistants by the Iowa CareGivers Association, most respondents said they had had three days of orientation, [103] which all but two of the respondents agreed was not enough. Furthermore, orientation generally consisted simply of working alongside other nursing assistants who were not prepared — or inclined — to train new hires. "People doing the orientation just don't have the gumption, the interest they should have," said one respondent. "They just put you with whoever."

The people charged with orienting new hires often resent the time required of them, for which they rarely receive extra pay, and take out that resentment on the new worker. "Nursing has a tendency to eat their young," says researcher Joanne Rader. "A new aide can come in, wanting very much to do a good job, and not feel welcomed by the other aides, who immediately judge her as not being good enough, not knowing how to do it."[104]

7.9.2 Supervision

Effective supervision is an important part of assuring good care. Regular monitoring and input from supervisors helps nursing assistants master and incorporate new procedures and identify and overcome barriers to quality. In the Iowa Caregivers Association nursing assistant poll, respondents noted that they stay at or leave their jobs because of the quality of their relationship with their direct supervisor.[105]

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[101] Carter Catlett Williams. Relationship The Heart of Life and Long Term Care. The Pioneer Network. March 2001.

[102] In their own words: Pennsylvania's frontline workers in long term care. (February 2001) A report to the Pennsylvania intra-governmental council on long term care (Harrisburg, Pennsylvania).

[103] Hill Simonton Bell 1999.

[104] Personal communication.

[105] Hill Simonton Bell 1999.

A pair of recent studies demonstrates that fact. When Burgio et al. (1994) taught nursing assistants a way of minimizing residents' urinary incontinence through prompted voiding, they built monitoring by specially trained nurse supervisors into the program, convinced that it was of central importance. The program had a positive effect on nursing assistant behavior and residents' continence rates, both of which were maintained over time,[106] but there was no way of separating the effects of the training from those of the supervision. Stevens et al. (1998) then tested the same model in another nursing home. This time, nursing assistants on some units were monitored by trained supervisors, but those on other units were not. Both sets of nursing assistants performed better on certain job measures immediately after they underwent the skills training, but only those on the units with formal management maintained their improvements after four months.[107]

Effective supervision is an art, and few people can master it without training, practice, and supervision of their own skills. Nurse supervisors must correct behaviors and enforce good care without being punitive or harsh. At the same time, they must help nursing assistants manage the considerable physical and emotional demands of the job. Good supervisors model the development and maintenance of respectful relationships with staff and residents. They act as advocates for both nursing assistants and residents, helping CNAs solve problems while holding them responsible for maintaining high standards of care. As Williams (2001) put it: "For relationships between supervisor and CNAs to develop and thrive ... CNAs need to know that they *are* recognized, appreciated, cared about, understood, and that there is someone standing in union with them."

Yet most charge nurses receive no supervisory training, and many are uncomfortable in their role as supervisors. In a report on focus groups with 36 licensed nurses who work in nursing facilities, Schirm et al. (2000) found that their respondents "consistently expressed a dislike for their role as supervisors of nursing assistants and frequently stated they were ill prepared for these responsibilities."[108]

Cultural differences may add to the discomfort. Supervisors are often of a different ethnic group, class, and/or culture than the nursing assistants they supervise. Sometimes they do not even share a primary language. And in the hierarchical world of healthcare, a nurse's professional license and years of clinical and classroom training confers much greater status than a nursing assistant's certificate and 75 or so hours of training. These differences are often barriers to good

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[106] Burgio, L.D., McCormick, K., Scheve, A., et al (1994). The effects of changing prompted voiding schedules in the treatment of incontinence in nursing home residents. *Journal of the American Geriatrics Society*, 42: 315-320.

[107] Stevens A., Burgio, L.D., Bailey, E, Burgio, K.L., Paul P., Capilouto E., Nicovich P. and Hale G. (June 1998). Teaching and maintaining behavior management skills with nursing assistants in a nursing home. *Gerontologist* 38(3): 379-384.

[108] Schirm V., Albanese T, Garland T.N., Gipson G and Blackmon D (August 2000). Caregiving in nursing homes: Views of licensed nurses and nursing assistants. Clinical Nursing Research 9(3): 280-297.

communication and mutual understanding, and can cause nursing assistants to feel disrespected by their supervisors.[109]

In a poll question posted in July 2001, the moderator of the NursingAssistant@yahoogroups.com listserv asked members how nurses could show more respect towards CNAs. The following responses illustrate many of the ways in which nursing assistants often feel unappreciated, unfairly treated, or ignored by their supervisors:

- Call me by my name;
- Ask me about my concerns;
- Ask me for input into my assignments;
- Allow me and my peers to make out our own assignments;
- Check in with me during the shift;
- Enable me to attend care plan mtgs;
- Host staff/unit/shift meetings;
- Share important info with me;
- Ask for my input about residents;
- Listen to me when I am worried about residents;
- Help me with setting goals;
- Enable me to go to in-services and seminars;
- Advocate for my work;
- Stick up for me;
- Speak to me with respect and dignity;
- When I make a mistake, let me know right away, privately;
- Help me by answering call bells;
- Assist me with lifts;
- Assist with feeding, bathing;
- Help me when I am in conflict with others;
- Don't play favorites;
- Stay away from cliques;
- Hear all sides first, seek to get facts;
- Act on my concerns about resident health; and
- Assume role of team player vs. BOSS;

Some facilities have reacted to this cultural divide by relieving their nurses of many management duties, appointing a non-licensed unit or program manager to do such things as hire, train, evaluate, discipline and schedule nursing assistants. This leaves the nursing staff free to concentrate on clinical work and documentation, with nursing assistants reporting to them only for matters directly related to care.

[109] Tellis-Nayak and Tellis-Nayak 1989.

Other employers are implementing a coaching model of supervision. Coaching is a style of supervision that focuses on supporting the growth of workers, as opposed to the more traditional "discipline and punish" approach to addressing problems. In addressing job performance concerns, the coach has two roles: the first is to be clear and straightforward about the problem and its consequences; the second is to help the person being coached to reflect on her thinking and behavior, consider different perspectives or possibilities, and actively make decisions to ensure that the problem does not recur. For details, see the description of the Cooperative Healthcare Network in Section 7.16.2.

7.9.3 Organizational Support

Good supervision is important, but it is not enough to guarantee good care. Sheridan et al. (1992) surveyed 558 direct care workers in 25 nursing facilities, including 23 that passed state inspections within a year of the survey and two that failed to meet minimum standards. In looking for characteristics more common to the poorly rated facilities than the others, the only clear link they found was to organizational climate. The unsuccessful facilities were rated lowest in human relations, their administrative practices having been judged as showing less of an interest in the well being of their employees and doing less to improve staff relations. They were also judged highest on laissez-faire climate (failure by the administration to establish clear objectives, inadequate resource planning, and a lack of incentives for doing a good job) and status orientation (administrative practices that emphasize status difference and create conflicts between departments.) "Administrators cannot blame ineffective staff members or supervisors for poor care," the authors concluded. "Often the management system is the root cause of poor quality."[110]

Smyer et al (1992) found that five one-and-one-half-hour classes on causes and management of problem behaviors in residents left a group of nursing assistants more knowledgeable but had no effect on their job performance, as rated by their supervisors. Calling their findings "sobering," the authors hypothesized that it was due to the fact that the facility did not adequately support the new way of doing things. They concluded that "administrative training and technical assistance support must be pursued at the same time that staff initiatives are undertaken. Without such administrative support we are unlikely to substantially affect the quality of care in nursing homes."[111]

Robert Atchley's research has led him to a similar conclusion. "The greatest determinant of the quality and effectiveness of training are the attitudes top management have about training," he says.[112] "Organizational values about the importance of front-line staff, inclusion of front-line

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[110] Sheridan John E., PhD., White John and Fairchild Thomas J., PhD. (1992) Ineffective staff, ineffective supervision, or ineffective administration? Why some nursing homes fail to provide adequate care. *Gerontologist* 32: 334-341.

[111] Smyer M, Brannon D, Cohn M (June 1992). Improving nursing home care through training and job redesign. *Gerontologist* 32(3):327-33.

[112] Personal communication.

staff in care planning, and ongoing training of front-line staff all have to be translated into management behavior rewarding those values or the organization will not show much effectiveness of training, no matter how well-designed the training program is."

7.10 Ongoing Education

In-service classes are the only form of continuing education nursing assistants are required to have, and the federal regulations regarding what they must consist of are brief. In-service education must be "sufficient to ensure the continuing competence of nurse aides."[113] Most classes should be geared toward a nursing assistant's areas of weakness as determined in annual performance reviews, although some may address the special needs of a resident or group of residents.

The only specific federal requirement is that nursing assistants who work with the cognitively impaired must attend in-services on how to care for that population, and that all nursing assistants must attend 12 hours of classes a year. Some states require more than 12 hours. Many also mandate that certain subjects must be taught every year.

7.10.1 What's Taught

The verdict on in-service education is close to unanimous—and bleak. As the name implies, the training takes place in the facility, usually while attendees are on the job. Units usually last an hour or less, allowing little time for reflection, and the material is nearly always presented in the form of an uninspired lecture or videotape.

Despite OBRA's mandate that the content be tailored to a nursing assistant's areas of deficiency, few facilities have the resources to present more than a one-size-fits-all agenda, especially in states that require certain topics to be covered each year.

In a review of in-service instructional materials for dementia care, Kramer and Smith (May 2000) found 14 guides, all but four of which relied on the same teaching model. This model, wrote the authors, "could be characterized as having an 'expert' who is not a nursing assistant instruct persons who are nursing assistants in principles of dementia care. Implicit in this model is the idea that the students, i.e., nursing assistants, know relatively little about the topic under discussion and will profit most by listening to the instructor. Typically, a non-nursing professional presents information in a relatively didactic style of teaching, with occasional group discussions and periodic presentation of hypothetical cases to support and clarify points made in the lectures."

Most states require annual sessions on OSHA standards, residents' rights, and fire and safety procedures. Lifting techniques and skin care are also commonly taught. Another common

[113] Federal Regulations, Title 42, Part 433, subpart B, section 483,75 (e)(8)(i, ii and iii).

type of in-service is held when a facility buys a complex piece of equipment such as a patient lift or a ventilator, and staff is convened to learn how to use it.

"Most employers cheap out on training; they use poor materials and poor trainers," says Robert Atchley. "Employers tend to see training as a waste of time and money and a regulatory pain in the neck instead of an opportunity. This sends a negative message to the trainees."[114]

Furthermore, the people who develop in-service programs rarely ask nursing assistants what they want to learn. "There's a [false] sense that nursing assistants don't know what they need to know," notes Genevieve Gipson. [115]

A "best practices" survey of nursing facilities in Pennsylvania, New York and Illinois uncovered some of the more specialized or advanced topics that may be covered in in-services. Respondents often taught in-services on pain management, joint and musculoskeletal problems, diabetic care, customer service survey etiquette, wound and pressure sore management, residents' rights, advanced nutrition and hydration, restorative care, improving documentation, and skin care. Also taught, though less often, were topics such as hospice care, cultural diversity, tender touch and sexuality.[116]

7.10.2 Who Determines the Content

A few nursing facilities have a full-time or part-time employee devoted solely to staff education, but most nursing facilities cannot afford this, or are not willing to assume the expense, as the costs associated with a full-time trainer are not necessarily reimbursed through their Medicaid rate. As a result, most fold those responsibilities into the job of an administrative nurse--usually an already overburdened director of nursing or assistant director of nursing.

Because of the competing demands on their time, heads of in-service generally welcome offers from anyone willing to present a program, and it's generally left up to the volunteer to decide what and how to teach. Representatives of equipment or medical supply companies often conduct in-services, explaining general caregiving procedures along with tips about their products.

7.10.3 Connecting Ongoing Education to Experience on the Job

There is little evidence to prove whether in-services improve nursing assistants' skills and residents' quality of care. In one study, facility managers were asked whether their in-service programs had a positive effect on job retention and care delivery. While the overwhelming

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[114] Personal communication.

[115] Personal communication.

[116] Hegeman C. and Lambating F. (April 2000). Best practice survey of nursing home aide continuing education programs. Foundation for Long Term Care (Albany, NY).

majority said yes, more than 80 percent admitted that they based that belief on "impression or anecdotal information." Only a small minority had formal evaluations to back up their claims.[117]

Meanwhile, nursing assistants and nursing assistant educators tend to be skeptical about the efficacy of in-service training. As noted in Section 7.10.1, in-services often fail to cover what attendees need to know.

Furthermore, the processes taught in in-services are not usually encouraged on the floor. "I think, for the most part, we teach [nursing assistants] right," says Acello. "But then they go back to the floor and do things the way they've always done them. They don't have time to do it the way we teach. In the real world, with staffing shortages the way they are, you've got to hustle." [118]

Burgio and Burgio (1990) also concluded that follow-up was key after studying training methods in other healthcare settings in order to recommend a model for training nursing assistants in long-term care. Successful in-services, they concluded, included three things. First was "didactic instruction, presented both verbally and in a written format; modeling of the procedure by the trainer (either in-vivo or via videotape); role playing of the procedure by the trainee; and immediate performance feedback by the trainer." Second was "a checklist assessment of skill performance in an analogue situation," giving the trainer an opportunity to provide "immediate, corrective feedback and praise." The third step, which the researchers called "crucial though often overlooked," consisted of assessing the trainee's performance on the job. "These assessments should be conducted immediately following the in-service and at regular intervals thereafter," the researchers advised. "If staff perform poorly during these assessments, they should be required to attend remedial training sessions." [119]

7.10.4 How Much In-service Education Nursing Assistants Get

Our sources were almost unanimous in agreeing that nursing assistants probably attend close to the mandated 12 hours a year. However, several experts question whether nursing assistants always get a full hour of in-service training for every hour logged, noting that students who train in nursing facilities are often called out of class to answer call lights or perform other duties, especially if the facility is short-staffed.

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[117] Hegeman and Lambating, April 2000.

[118] Personal communication.

[119] Burgio L.D. and Burgio K.L. (1990). Institutional staff training and management: A review of the literature and a model for geriatric, long-term-care facilities. International Journal of Aging and Human Development 30(4):287-302.

7.11 Who Pays for Education and Testing

7.11.1 OBRA Mandates

Federal law is clear on who should pay for the certification training required of nursing assistants who work in nursing facilities. According to federal regulations, students who are employed by a nursing facility or who have received an offer of employment from one when they begin taking classes may not be charged for "any portion of the program (including any fees for textbooks or other required course materials."[120] In such cases, the nursing facility that employs or will employ the newly certified nursing assistant must pay for the classes. The state will then reimburse the facility for at least part of its costs. (For details, see Section 7.11.3.)

Some nursing assistants in training pay for their classes and course materials, having had no job or offer of employment at a nursing facility when they started class. The state must also reimburse the cost of training for these students, if they start work at or receive an offer of employment from a nursing facility within 12 months of becoming certified. In such cases, payment is to be made through the nursing facility that hires the new worker, which repays him or her and then applies for reimbursement from the state. Some states direct facilities to repay nursing assistants on a pro rata basis over the course of a year or less, until the full amount is paid off or the worker leaves the facility, whichever comes first. [121]

Despite these mandates, however, nursing assistants who pay for their certification training and testing are not always repaid, even when they go to work for a nursing facility within a year of getting certified (for details, see Section 7.11.4)

7.11.2 The Cost of Initial Certification Education and Testing

The reported cost of certification and training varies widely. According to one decade-old study, the cost for both combined averaged $1,859.[122] A more recent study reported average training costs of $1,604 for government-operated nursing facilities and $1,066 at privately operated facilities.[123] The government facilities tended to provide substantially more hours of training per student, which presumably explains the difference.

The considerable differences between these reported costs may be explained in part by the variation in state requirements (longer courses presumably cost more), where the classes were held (urban classes are probably more expensive than rural ones), and by variations in the formulas used to calculate costs. Other variations include whether the nursing facility pays the students for their time while learning and whether it pays a third party to provide the education.

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[120] Federal Regulations, Title 42, Part 483, subpart D, section 483.152 (c)(1).

[121] Federal Regulations, Title 19, Section 1919(f)(2)(a)(iv); Title 18, Section 1819(f)(2)(a)iv; Title 42, Volume 3, Part 483, subpart D, section 483.152 (c).

[122] Zahrt, Linda M. (April 1992) The cost of turnover in a home care agency. *Caring.*

[123] Pennsylvania's Frontline Workers, February 2001.

7.11.3 The Cost to Nursing Facilities

Because nursing facilities employ so many nursing assistants and their turnover rate is usually high, the cost of educating new nursing assistants adds up fast. The annual cost of certification training for Pennsylvania's nursing facilities, for instance, is estimated to be more than $21 million.[124] Some facilities are disinclined to invest in training because many trainees leave soon after finishing training, some of them to work in home care or acute care after getting trained free of charge at a nursing facility.

The American Health Care Association, the largest trade association for long-term care providers, performed an informal canvass of its state affiliates for this chapter to ascertain the cost of certification training. The 19 state affiliates responding to AHCA's e-mailed questions reported average per-student costs as low as "between $150 and $500 depending on facility and class size" and as high as $2,000, with the great majority ranging from $400 to $1,000.[125] The higher reported costs were usually associated with licensed schools.

Depending on where they operate, nursing facilities may not be reimbursed the full cost of certification training. Training and competency evaluations are not included in a facility's daily Medicaid reimbursement rate for medical expenditures. Rather, they are considered part of the costs of administering the state's Medicaid program. Facilities pass their training and education expenses directly to Medicaid, which reimburses from the state's administrative cost center. Some states initially add training expenses to the per diem paid to the facility for medical expenses, but when the final cost settlement is made between the state and the facility, the facility passes costs for CNA training on to the state as an administrative expense.

States may impose "reasonable cost guidelines" based on the median cost of training reported by all facilities in the state, or by a pre-determined group of facilities. In such cases, facilities are paid in full for all eligible expenses up to a certain point, which is usually more than the median cost.

States may impose other limits as well. In Oregon, for instance, facilities are reimbursed based on the percent of Medicaid clients served at the facility, so if 75 percent of its residents are Medicaid recipients, a facility will recover 75 percent of its allowable training costs.[126]

7.11.4 The Cost to Nursing Assistants

Feedback from providers and nursing assistants indicates that relatively few nursing assistants pay in full for their education and training, although the percentages appear to be higher in some states than in others.[127]

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[124] Pennsylvania's Frontline Workers, February 2001.

[125] Memo to Tom Burke from Janet A. Myder, Director Regulatory Systems. American Health Care Association (AHCA), July 24, 2001.

[126] AHCA memo, July 24, 2001.

Nursing assistants in need of certification education have three payment choices: pay in full at a private school, pay part of the cost in a subsidized program, or attend classes at the expense of a nursing home. Even those who initially shoulder the cost are often repaid.

An informal poll of members of the NursingAssistant@yahoogroups.com listserv conducted for this chapter illustrates some of the ways in which nursing assistant educations are subsidized. Over half of the respondents (six) attended classes free of charge at a nursing home. Four paid out of pocket, but half of these were heavily subsidized by scholarships or grants. One paid just $75 for training, including the cost of textbooks, and another $50 for testing; the other paid $75 for training and can't remember what she paid for the test, indicating that its cost as not steep. Costs were substantially higher for the other two. One paid $40 for a textbook and $300 for training and testing; the other paid $450 for training and testing. However, the former was reimbursed when he went to work for a nursing home, and the latter would have been reimbursed by the nursing facility that trained her if she had agreed to work there for at least six months (instead, she opted to work for a hospital).

Some training is subsidized by programs like the federal Workforce Investment Act (WIA), which distributes money to the states for job training. State-funded and other scholarships and grants help pay for nursing assistant training at community and vocational-technical colleges. However, WIA funds typically have not been available to train workers for jobs with such poor wages and benefits.

Although nursing facilities are supposed to reimburse the cost of training for new hires who were certified within the past year (see Section 7.11.1), anecdotal evidence indicates that compliance with this rule varies from facility to facility and possibly from state to state. Three of the key contacts interviewed for this chapter, who are each in regular contact with many nursing assistants nationwide and who live in three different states, all said that they had heard of numerous instances in which facilities did not comply. "Homes generally don't want to fiddle with the paperwork, so they usually pretend they don't know how," said nursing assistant educator Barbara Acello. Ohio-based nursing assistant educator Genevieve Gipson believes that reimbursing eligible new hires is the exception rather than the rule in her state. "It just doesn't happen," she said. Nursing assistant Patricia Green agreed, saying "Many places don't let CNAs know they can be reimbursed by the state."

7.11.5 Cost as a Barrier to Entry

The cost of the education is a barrier to some. As outlined above, some students must come up with hundreds of dollars for classes and textbooks — an unattainable sum for many people who live from one paycheck or public assistance check to the next. Even a relatively small amount, such as $75 for a test, may be more than a mother struggling to feed her children can afford to spend.

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[127] AHCA memo, July 24, 2001.

The cost of classes and materials is not the only barrier. People living at subsistence level and working two jobs or hurrying home after work to look after young children at home do not always have the time to attend classes unless they are paid for the time spent in training, and most nursing assistant certification classes do not pay students for their time.

Conflicting government policies are another impediment to entry for low-income would-be workers. As Dawson and Surpin (2001) point out: "state and federal employment agencies often preclude the long-term-care industry from participating in training support programs—on the basis that graduates of such programs cannot earn a livable wage as direct care workers."[128]

The federal requirement that nursing assistants get specialized training also puts the job out of reach of many people who are trying to move from public assistance into the workforce. The 1996 law that restructured welfare includes "a presumption, often referred to as 'work first,' that discourages entry-level, skill-based training as a pathway to employment," the authors explain. That policy endorses "immediate attachment" to a job, which "discourages low-income women from gaining access to training as a pathway to healthcare work."

7.11.6 Continuing Education and Career Advancement Opportunities

Aside from the OBRA-mandated in-services provided by nursing facilities (see Section 7.10), continuing education for nursing assistants is hard to come by. Perhaps as a result, employers are rarely willing to pay to send nursing assistants to conferences. Nursing assistants are rarely able to shoulder the costs themselves, first because the cost of travel, a hotel room and meals is usually prohibitive and secondly because they must often take the time off without pay. However, a handful of conferences have recently begun to target or include nursing assistants, and a growing number of nursing assistants attend them every year.

The Career Nurse Assistants Program (CNAP)(see Section 7.16 for details) hosts a national nursing assistant leadership conference every fall in conjunction with NCCNHR's annual meeting, covering travel costs for some nursing assistants who couldn't otherwise afford to attend. The Direct Care Alliance (DCA), a national network of long-term care consumers, workers and concerned providers, dedicated to ensuring a stable, valued, well-trained direct care workforce, also includes nursing assistants as both participants and presenters in its twice-yearly meetings and conferences, raising funds to pay for their travel expenses. At both DCA's and CNAP's meetings, nursing assistants practice leadership development, learn and report about public policies affecting long-term care, and exchange information and insights with consumers, providers and workers from other states. The National Association of Geriatric Nursing Assistants (NAGNA), a professional association for nursing assistants, hosts an annual national convention. NAGNA pays travel expenses for the winner of an essay contest each year, but other attendees must cover their own costs. Several states have also held regional or statewide meetings.

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[128] Dawson, Steven L. and Surpin, Rick. (Spring 2001) Direct-care healthcare workers: You get what you pay for. *Generations* 25(1): 23-28.

At least two publications address nursing assistants' professional concerns as well. *Nursing Assistant Monthly*, an educational program produced by Frontline Publishing (www.frontlinepub.com), addresses the challenges faced by nursing assistants in themed monthly issues, pairing a newsletter for nursing assistants with instructional materials for nurse supervisors (see Section 7.16 for details). Participating nursing facilities pay to have the newsletters sent to all their nursing assistants. *CNA Today*, launched by NAGNA in the summer of 2001, is a quarterly magazine that costs $25 a year for NAGNA members and $35 a year for nonmembers (www.nagna.org).

For the most part, nursing assistants who want to further their educations must do so at their own expense or find free sources of information. For the small but steadily growing number with regular access to the Internet, a handful of websites and e-mail listservs for nursing assistants[129] can provide a good starting point. As nursing assistant Melissa Lothrop recently wrote to the NursingAssistant listserv: "Recently, I got a computer and found this website, just by looking for information in my field... I've learned of magazines and articles and the way the rest of the country works in my field."[130]

7.12 What's Often Missing in Preparing Nursing Assistants for the Job

> *"We should raise the bar for CNAs regarding training and orientation. For years now we have complied with the regulations, but at the same time lowered our expectations. This has been done because of our immediate and critical need for nursing assistants. There is an urgency to get them 'trained' and through class (usually 75 hours of classroom/instructor) so they can be utilized on the floor. However, because it is such a rushed situation, sometimes there is not a thorough comprehension, there is not mastery of skills... Often orientation in a facility is the same as training: rushed, hurried, unorganized, and chaotic. Many times it is not the best CNA trainer who is doing the orientation."* [131]

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[129] These include NursingAssistant@yahoogroups.com, http://www.directcareclearinghouse.org, http://network54.com/Forum/11252?it=, http://www.homestead.com/nurscassistant/Homc.html, http://venus.beseen.com/boardroom/i/26493, http://www.cna-network.org, http://hcassidy.tripod.com/FANA/FANA.html and http://www.nagna.org.

[130] Response to a question from nursing assistant Connie Trendel, who was writing an article for *CNA Today* magazine about nursing assistants taking responsibility for their own educations.

[131] Personal communication with Lisa Cantrell, RN, C, co-founder and president of the National Association of Geriatric Nursing Assistants (NAGNA).

7.12.1 Recruiting the Right People

Facilities that hire the wrong person cannot erase the mistake with any amount of training. Nobody wants to make that mistake, yet it appears to happen frequently. In a study of nursing assistants who are active registrants in North Carolina's nurse aide registry, Konrad (2001) found that "less than half of the 180,000 North Carolinians trained to work as nursing assistants during the last decade are currently certified to work as a nurse aide. Even among those who are certified, many seem to work only part-time as a nurse aide and supplement this income with earnings from other unrelated jobs in low wage industries. Those who used to be certified as CNAs have mostly left the [long term care] field and appear to have more stable jobs at higher wages in other industries."[132]

A similar probe by the Florida Education and Training Placement Information Program showed that only 53 percent of the people who had joined the state's CNA registry in the year beginning July 1, 1997, were working in a health-related field up to a year later. [133]

To reduce its approximately 100 percent annual turnover rate among nursing assistants, the Lovington Good Samaritan Center in Lovington, New Mexico, instituted a new hiring and recognition program in March 1997. While the program also includes awards and financial incentives, its core philosophy is "Hire for character and train for skills," and it revolves around a hiring policy in which the employer looks for people who exhibit certain character traits. The facility reports that the program improved staff morale, lowered turnover among CNAs (the rate was 14 percent lower in the first quarter of 1998 than in the first quarter of 1997), saved the facility a considerable sum in sick time, overtime and hiring costs (those costs totaled $14,600 less in the first quarter of 1998 than in the same quarter the previous year). [134]

7.12.2 What Keeps Candidates Out of Certification Classes

Literacy Skills

With shortages of frontline workers already severe and growing in most parts of the country,[135] facilities can ill afford to discourage qualified candidates. Yet some interested candidates who would be good at the job simply can't pass the certification test.

In the late 1980s and early '90s, as long term care geared up to implement the certification training and testing mandated by OBRA '87, a number of seasoned nursing assistants feared they

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[132] Konrad, T R (2001). Where have all the nurse aides gone? North Carolina Institute on Aging.

[133] Brian Peacock Consulting Inc., January 2000.

[134] Brian Peacock Consulting Inc., January 2000.

[135] Paraprofessional Healthcare Institute (January 2001). Direct-care health workers: The unnecessary crisis in long-term care. The Aspen Institute Domestic Strategy Group, Washington, DC.

would be unable to pass the test. As nursing assistant educator W.H.Heaton reported at the time, "The majority fear taking a written examination because of their inexperience in test-taking." [136]

Apparently, those fears were well founded. Heaton tested about 150 nursing assistants on 100 items that would be covered in the federally mandated curriculum. The subjects were experienced nursing assistants in good standing, averaging eight years on the job. Yet only 10 (6.7 percent) passed the test, and their average score was 58 percent.

The nursing assistants, noted Heaton, did best on "areas that are taught most often in a facility's in-service training programs—skin care, intake and output, care plans, psychological aspects of dying and restraints." This indicated, he said, that part of the problem was lack of knowledge, and that more education in specific areas was needed. But for the most part, Heaton believed, the nursing assistants knew what to do on the job; they just didn't know how to pass written tests. "The majority of those tested have been away from the academic environment for several years and are not familiar with how tests are now administered," he wrote. "Many indicated that they had a problem with reading comprehension. They simply did not understand the questions. This is not because the questions are difficult, but because the terminology used in formulating the questions is foreign to them."

Literacy standards may have been too low for nursing assistants before OBRA. Illiteracy can compromise care quality, as some competency in both written and spoken English are needed in order to communicate about complex care needs, chart work done and observations made, and to read and comprehend written instructions. For example, if employees do not understand instructions well enough to learn why it is important they do a specific activity in a certain way — such as place used sharp objects in a "sharps disposal box"— then quality could be compromised. Lack of fluency in English can also create a barrier in communicating with residents, unless most of the residents in the facility speak the nursing assistant's primary language.

However, Heaton's findings indicate that current educational and testing requirements eliminate many people who would make good nursing assistants if their language skills could be brought up to speed. For many, the solution would be a graduate equivalency degree (GED) or an English as a second language (ESL) classes, but prospective students generally find these difficult to find, pay for, and graduate from.

Some nursing assistants manage to get certified, learning enough in class to pass the oral exam, and then access ESL classes through their employers. While the researchers for this chapter were unable to investigate the prevalence of such programs, discussions with key contacts uncovered a few. At Providence Mount St. Vincent, for instance, supervisors at the Seattle nursing facility noticed that many of their nursing assistants were neither fluent in English nor proficient in reading and writing in their own language. In response, the facility

[136] Heaton WH. (March 1989) Examining nurse aide competency evaluations. *Contemporary Long Term Care*. 12(4):23-4, 38.

began to use pictorial presentations on some instruction sheets, and to offer ESL training throughout the year to all interested employees. [137] (For details on Providence Mount St. Vincent's training programs, see Section 7.16.)

Other Hurdles

Retaining newly trained employees requires employers to devote serious attention and resources to employee supports. Nursing assistant work often entails off-hour employment, sometimes in more than one site. Therefore, community services such as evening or overnight childcare and transportation must be arranged, most likely through community-based services.

As noted in Section 7.4, most nursing assistants are low-income women. Some straddle the worlds of welfare benefits and health care employment, leaving welfare for work but cycling back to public assistance as soon as the next family crisis hits. Others receive cash, food stamps, and other forms of public assistance even while employed as direct-care workers, because their jobs offered only poverty-level income. Still others lack basic job skills and need education in the importance of showing up on time, dressing professionally, and so on.

A recent report aimed at helping state and local governments transition welfare recipients into the workforce[138] outlined the following common barriers to employment:

- substance abuse,
- domestic violence,
- physical disabilities and chronic health problems,
- depression and other mental health problems,
- criminal records,
- very low basic skills and learning disabilities, and
- language barriers.

The author estimates that between a quarter and a half of the people currently on welfare probably face at least one of these barriers, some of which — e.g., substance abuse, certain types of criminal records, and certain physical disabilities — would disqualify them from work as a nursing assistant. But, with enough desire and effort on the part of the employer and employee and with help from government programs, most of these barriers could be surmounted.

Government programs would have to go farther than usual, the author notes, providing "additional support services, beyond those traditionally provided by welfare-to-work programs (such as child care and transportation), These include mental health counseling, shelter for victims of domestic violence, and substance abuse treatment." Employers must also be prepared to make extra provisions, as "[t]he path from welfare to work is not linear. Some problems must

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[137] Personal communication with Charlene Boyd, Providence Mount St. Vincent administrator.

[138] Brown, Amy (April 2001). Beyond work first: How to help hard-to-employ individuals get jobs and succeed in the workforce. Manpower Demonstration Research Corporation.

be addressed before individuals begin work, others can be addressed while they are working, and still others may not even emerge until after they have begun to work."

Employers in the Cooperative Healthcare Network, who frequently hire women who are entering or re-entering the workforce after being on public assistance, have found certain approaches effective in helping new employees make the adjustment.[139] For details, see "Easing the transition to work."

Easing the transition to work

Cooperative Healthcare Network employers use these strategies to help trainees and new employees transition into the workforce.

- Full-time counselors help employees access community supports such as transportation, childcare, children's health insurance, or housing assistance.
- A structured support system responds to employee needs systematically with assistance such as a credit counselor or a small loan fund managed by a committee of employees.
- A "coaching" model of management emphasizes problem solving over disciplinary actions.
- Training is tailored to the individual employee and designed to strengthen the candidate's critical thinking, problem solving and communication abilities, to prepare the trainee for both the content and the performance expectations she will find when she begins work.
- High standards of work performance and professional behavior are rigorously enforced.

7.12.3 What's Missing from Certification Training and In-services

In general, most nursing assistants and nursing assistant educators agree on a few key points. Certification education should last for more than 75 hours and should include a significant clinical component (see Section 7.9.1). In-services should be less repetitive and more tailored to the needs of individual residents and staff members, with more advanced topics covered for the more experienced workers (see Section 7.10.2). As one group of nursing assistants observed, "Deficiency driven [in-service] training is the rule at present, rather than development of knowledge and skills that can prevent deficiencies."[140]

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[139] Paraprofessional Healthcare Institute (1997). Welfare to work: An employers' dispatch from the front by the Cooperative Health Care Network. Bronx, New York.

[140] NCCNHR 1988.

As to specifics, every topic listed below is covered well by some facilities or schools, as programs vary widely. Overall, however, these areas tend to be either absent or underdeveloped in educational programs for nursing assistants.

7.12.4 Orientation and Supervision

Good supervision and orientation help reinforce learning from the classroom and model the values of the organization. The CNA develops a positive relationship with her supervisor, which becomes an important model for relationship building with residents and other staff in the facility. Conversely, not getting along with a supervisor is one of the main concerns nursing assistants cite about their jobs. [141]

Orientation introduces the new CNA to the culture and relationship environment in the facility. It is through this introduction she learns the values of the facility: how staff treat each other and residents and family members, how to work in teams, whether relationship building is important. As Williams (2001) wrote: "We need to fuel each other with the positive energy of regard for the other person. If CNAs do not have that from supervisors and fellow workers, what do they have to give to residents?"

Yet nursing assistants all too often must do without effective, well-organized orientation or supervision (see Sections 7.9.1 and 7.9.2).

7.12.5 Problem Solving and Critical Thinking

Despite the title, nursing assistants are not just assistants to nurses. In fact, some facilities, such as Seattle's Providence Mount St. Vincent, call their CNAs resident assistants in an effort to emphasize the fact that their role is to help the residents, not the nurses.

Among the many dilemmas nursing assistants face are the following:

- Seeing peers do things they were taught not to do in training;
- Residents responding unfavorably to care, although it is delivered the way they were taught to;
- Peers not responding to requests for help;
- Interacting with a supervisor who you feel is treating you unfairly;
- Handling a resident emergency;
- Being asked by a nurse to do something outside the job description, i.e., give a medication or administer a treatment;
- Being offered money by a family or resident to take special care of them; and
- Being unfairly accused of abuse.

[141] Iowa Caregivers Association, December 2000.